Women's Health Benefits Survey

A Report by the Washington State
Office of the Insurance Commissioner

Mike Kreidler
Washington State Insurance Commissioner

2000-2001

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OFFICE OF THE INSURANCE COMMISSIONER

WOMEN'S HEALTH BENEFITS SURVEY

EXECUTIVE SUMMARY
2000-2001

In 1998, the Office of the Insurance Commissioner (OIC) in Washington State conducted a survey of women's reproductive health benefits. The survey was prompted by questions and complaints (mostly from women) received by the OIC from January 1996 to October 1997. It reviewed the benefit coverage of services that are critical for the reproductive and sexual health of women, men and families. The survey described 91 top-selling plans with a combined enrollment of 1,399,650 individuals from a market-representative sample of 12 health insurance carriers.

OIC found wide variations in coverage of core services by plan type and identified particular gaps in coverage for women's health benefits. The most striking finding was the degree to which coverage for contraception and family planning services, devices, and medications lagged behind other health service coverage. While coverage for gynecologic, maternity, reproductive cancer screening, STD and human immunodeficiency virus (HIV) services was nearly universal, only three out of four plans covered sterilization and pregnancy termination services. Coverage for infertility services was much less. In addition, coverage of prenatal care for teen dependents of enrollees was inconsistent among plans. Important questions were identified regarding compliance with some laws that promote access, including coverage for newborns of dependents. The survey results were used by the Washington State Legislature to support various women's health policy initiatives (1998 OIC report).

Survey Background and Findings

In 2000, a follow-up survey was conducted. This time the survey included 114 top-selling plans from 25 different carriers.[1] Survey categories included:

- Gynecological care
- Maternity services
- Contraception and family planning
- Infertility
- Cancer screening
- Preventive care

[1] Aetna US Healthcare, Inc. , Aetna US Healthcare of Washington Inc., Aetna Life Insurance Co., Clark United Providers, Community Health Plan of Washington, First Choice Health Plan, Inc., Group Health Cooperative of Puget Sound, Kaiser Foundation Health Plan of the Northwest, Kaiser Permanente Health Alternative, KPS Health Plans, Molina Healthcare of Washington, Inc., Northwest Washington Medical Bureau, ONE Health Plan of Washington, Inc., Options Health Care, Inc., PacifiCare of Washington, Inc., Premera Blue Cross, Premera HealthPlus, Providence Health Plan (in Oregon, sells to Washington residents), Regence BlueCross BlueShield of Oregon, Regence Blue Shield, Regence Northwest Health, Regence Health Maintenance of Orgeon, RegenceCare, United Healthcare of Washington, Inc., Virginia Mason Group Health Alliance

- Mental health
- Midlife health
- Sexually transmitted diseases
- HIV

These 114 plans serve the following markets:
- 43.9% large and small group (n=50)
- 32.5% large group (n=37)
- 14.0% indemnity (n=16)
- 5.3% Medical Assistance Administration (n=6)
- 4.4% Health Care Authority (n=5)

Plans by carrier license include:
- 66% Health Care Service Contractors
- 28% Health Maintenance Organizations
- 6% insurance companies selling Indemnity products

These plans represent coverage for a total of 1,821,417 lives, approximately 39% of which are female. There were 453,749 women (64%) in the 15 to 44 year age group and 256,798 (36%) in the 45-and-over age group.

Respondents by plan types (organizational structure) include:
- 44.7% Primary care 'gatekeeper' or HMO-type managed care[2]
- 24.6% Point-of-service (POS)[3]
- 22.8% Preferred Provider Organization (PPO)[4]
- 7.9% Indemnity[5]

The following data are reported as a combined figure that includes whether the service is covered routinely ('yes' without restrictions) or covered with restrictions.[6] The term 'coverage', therefore, refers to coverage of any kind. Coverage is reported for every individual service in the section, as well as for overall coverage of the service by all carriers.

[2] Enrollees in these plans must use a Primary Care Provider (PCP) for specialty referrals, using contracted providers. Coverage/coinsurance levels are usually based on whether a provider is in a network. In some plans, if an out-of-network provider is used, there is no coverage.

[3] 'POS' plans encourage, but do not require, enrollees to choose a primary care provider. Plan members may opt to use providers within the network. Enrollees may use non-preferred providers, but at a higher cost.

[4] 'PPOs' are health care arrangements that provide incentives to enrollees (such as lower deductibles and copays) to use providers within their network. Enrollees may use non-preferred providers, but at a higher cost.

[5] 'Indemnity' plans traditionally reimburse the policyholder for incurred health care costs.

[6] Specific restrictions, such as age and monetary limits, are discussed in the full report.

Gynecological Care

Service definition: Pap smear, chlamydia screen, annual exam, clinical breast exam, sexual dysfunction screening/treatment/prescription drugs, and sexual health counseling.

Key findings:

- Pap smear, chlamydia screening, annual exams, clinical breast exams: 89-100% coverage by plan type; 98-99% coverage overall
- Mammograms: 100% coverage across all plan types (from Cancer Services category).
- Sexual health counseling: 66-86% by plan type, 81% overall

Core services coverage: Pap smear, chlamydia screening, clinical breast exam, annual exam, mammography.
91% of plans cover all five core services. By plan type, coverage is as follows:

HMO – 100%
POS – 100%
PPO – 69%
Indemnity – 78%

91% of females in the 15 to 44 year age group and 91% of females 45-and-over have coverage of all five core services. No significant difference exists in core coverage between the two surveys.

Comparison to 1998 OIC Reproductive Health Benefits Survey:
Coverage rates remain high for Pap smears, chlamydia screening, mammograms, annual exams and clinical breast exams. Coverage in 2000 for sexual health counseling appears to have decreased when compared to coverage rates in 1998, however the difference is not statistically significant.

Maternity Services

Service definition: Preconception counseling, prenatal testing, prenatal/OB care, prenatal vitamins/supplements, hospital delivery, home delivery, birth unit delivery, licensed midwives by provider type, postpartum care, newborn care, 21-day postpartum care of child of dependent, and prenatal care of teen dependents.

Key findings:

- Preconceptual counseling: 86-94% POS & HMO; 61%-66% PPO/Indemnity
- Prenatal testing and care: 88-98%, 94% overall
- Hospital delivery and postpartum care: 88-96%; 93% overall
- Birth unit delivery 88-90%, 90% overall
- Newborn care: 78-98%, 95% overall
- Home delivery: 43-89%, 61% overall
- Prenatal vitamins and supplements: 39-85%, 73% overall
- Midwife services: 69-96%, 89% overall
- 21-day postpartum care of an infant, as required by the ERIN Act (RCW 48.43.115): 62-90%, 81% overall
- Prenatal care of teen dependents: 75-79% POS/HMO; 8-11% PPO/Indemnity

Core services coverage: Prenatal testing and care, hospital delivery, postpartum and newborn care.
92% of plans cover all five core services. By plan type, coverage is as follows:

HMO – 96%
POS – 93%
PPO – 89%
Indemnity – 78%

95% of females in the 15 to 44 year age group and 94% of females 45-and-over have coverage of all five core services. No significant change exists in core services coverage between 1998 and 2000.

Comparison to 1998 OIC Reproductive Health Benefits Survey:

- Across all plan types, coverage for preconceptual care has risen. However, the increase is not statistically significant.
- Coverage for prenatal testing, prenatal care and hospital delivery are, overall relatively unchanged among plans from 1998 to 2000.
- Home delivery coverage has declined in HMO, PPO and Indemnity plans since 1998, with only POS plans showing an increase from 53% coverage in 1998 to 64% coverage in 2000. This is a statistically significant decrease in coverage over the two-year period.
- Birth unit delivery has increased slightly among HMO plans since 1998, while PPO and Indemnity coverage has decreased. POS coverage has remained about the same. Overall, there is no statistically significant difference in coverage between 1998 and 2000.
- Postpartum care coverage rates remain about the same.
- Newborn care coverage has decreased among Indemnity plans from 100% coverage in the 1998 survey to 78% coverage in the 2000 survey. (The two Indemnity plans that no longer provide this coverage are also no longer for sale.)

Contraception and Family Planning

Service definition: Contraceptive counseling, over-the-counter (OTC) contraception, intrauterine device (IUD), IUD insertion, IUD removal, diaphragm device, diaphragm/cervical cap fit, Norplant device, Norplant insertion, Norplant removal, DMPA injection, oral contraceptive pills (OCP) (including greater than 1 month supply), and emergency contraception.

Key findings:

- Contraceptive counseling: 67-94%, 84% overall
- Over-the-counter contraceptives: 0-14%, 7% overall
- IUDs: 11-77%, 76% overall
- IUD insertion: 11-90%, 69% overall
- IUD removal: 73-100%, 92% overall
- Diaphragm: 11-80%, 65% overall
- Cervical cap fit: 11-90%, 69% overall
- Hormonal implants (Norplant): 11-77%, 60% overall
- Norplant insertion: 11-86%, 64% overall
- Norplant removal: 73-90%, 88% overall

- Hormonal injections: 11-81%, 65% overall
- Oral contraceptive pills: 44-98%, 81% overall
- Emergency (post-coital) contraception: 44-79%, 65% overall

Core services coverage: IUD, diaphragm, Norplant, DMPA, and OCPs.
54% of plans cover all five core services. By plan type, coverage is as follows:

HMO – 66%
POS – 73%
PPO – 27%
Indemnity – 11%

69% of females in the 15 to 44 year age group and 70% of females 45-and-over have coverage of all five core services. No statistically significant increase exists in core coverage between 1998 and 2000.

Comparison to 1998 OIC Reproductive Health Benefits Survey:
All plans in the 2000 survey show an increase in coverage for contraceptive and family planning services over those reported in the 1998 OIC Reproductive Health Benefits survey. Increases for all services were highly or very highly statistically significant (except for OTCs, where the difference was not tested.)

Infertility

Service definition: Infertility diagnosis, infertility treatment, endometrial biopsy, endometriosis treatment, and assisted reproductive technologies (ART).

Key findings:
- Most plans cover endometriosis as a medical condition, but not for purposes of becoming pregnant.
- Infertility diagnosis: 11-69%, 55% overall
- Infertility treatment: 0-43%, 29% overall
- Endometrial biopsy: 100% across plans
- Endometriosis treatment: 98-100%, 99% overall
- Assisted reproductive technologies: 0-28%, 18% overall

Core services coverage: Infertility diagnosis and treatment.
29% of plans cover both core services. By plan type, coverage is as follows:

HMO – 39%
POS – 43%
PPO – 4%
Indemnity – 0%

20% of females in the 15 to 44 year age group and 20% of females 45-and-over have coverage of both core services. A small but statistically significant increase exists in coverage between 1998 and 2000.

Comparison to 1998 OIC Reproductive Health Benefits Survey:

- HMOs were the only plan type that increased coverage for infertility diagnosis over 1998 rates. All other plan types decreased coverage for this service. Overall, however, no statistically significant difference exists in coverage between 1998 and 2000.
- Coverage for treatment of infertility rose in HMO and POS plan types, but fell in PPO and Indemnity plans. The overall change in coverage of these services is not statistically significant.
- All surveyed plans (100%) now cover endometrial biopsy. This is a very highly statistically significant change from the 1998 survey, in which 50% to 86% of plans offered this type of coverage.
- Coverage (although with restrictions) rates for treatment of endometriosis remain high across both surveys.
- The rate of coverage for ARTs remains low at 18% overall, but is improved over the complete lack of coverage in 1998. This increase is very highly statistically significant.

Cancer Screening

Service definition: Pap screen, HPV screen, colposcopy screen, fecal occult blood screen, flexible sigmoidoscopy screen, mammography, breast cancer mastectomy, breast cancer lumpectomy, breast reconstruction, lymphedema screening and treatment (including provider types and limits), and post-op physical therapy.

Key findings:

- Mammography, breast cancer mastectomy and lumpectomy, and breast reconstruction all covered at 100%
- Lymphedema treatment covered at 89-100%
- Post-op physical therapy rehabilitative care covered between 66% and 86%, 77% overall
- Colposcopy, flexible sigmoidoscopy, and fecal occult blood screening: 73-100%, 92% overall

Comparison to 1998 OIC Reproductive Health Benefits Survey:

- As in 1998, mammography, breast cancer mastectomy and lumpectomy, and breast reconstruction are all covered at 100%.
- A statistically significant decrease in coverage has occurred for post-op physical therapy.

Preventive Care

Service definition: Chronic disease management and education, tobacco screen/treatment/cessation limits, obesity screening/surgical treatment, obesity screening/prescription drug treatment, obesity screening/behavior modification treatment, cardiovascular wellness programs (diet, exercise, fitness) pre-cardiac event, cardiovascular (CV) wellness programs (diet, exercise, fitness) post-cardiac event, cardiovascular screening (hypertension/stroke/MI risk), and diabetes screening/treatment/management.

Key findings:

- Disease management: 89-100%, 98% overall
- Tobacco screening/treatment: 22-82%, 67% overall
- Obesity screening/surgical treatment: 0-61%, 32% overall
- Obesity screening/prescription drug treatment: 0-22%, 16% overall
- Obesity screening/behavior modification: 0-33%, 19% overall
- CV wellness pre-event: 16-57%, 39% overall
- CV wellness post-event: 64-100%, 82% overall
- CV screen (HTN/CVA/MI risk): 67-94%, 85% overall
- Diabetes: 100% across all plans

Comparison to 1998 OIC Reproductive Health Benefits Survey:
This category is new to the 2000 survey.

Mental Health

Service definition: Depression screening/treatment, anxiety screening/treatment, inpatient treatment, outpatient treatment, and prescription drug treatment.

Key findings:

- Depression screening/treatment and anxiety screening/treatment: 67-100%, 93% overall
- Inpatient treatment: 67-92%, 90% overall
- Outpatient treatment: 67-100%, 94% overall
- Prescription treatment (e.g., Zoloft, Prozac): 67-100%, 94% overall
- Addiction screening/treatment: 67-93%, 88% overall

Comparison to 1998 OIC Reproductive Health Benefits Survey:
This section is new to the 2000 survey.

Midlife Health

Service definition: Incontinence screening/treatment, menopause hormone replacement therapy, menopause alternative therapies (e.g., herbal treatment), arthritis/immune disorders screening/treatment, osteoporosis screening/treatment/prescription drugs, and bone density.

Key findings:

- Incontinence screening/treatment, alternative therapy, arthritis/immune disorder screening, and osteoporosis screening/treatment/prescription drugs: 89-100%, 99% overall
- Hormone replacement therapy and bone density tests: 89-100%, 98% overall

Comparison to 1998 OIC Reproductive Health Benefits Survey:
This section is new to the 2000 survey.

Sexually Transmitted Diseases

Service definition: Sexual health history-taking, STD counseling, STD screening/ diagnosis, and STD treatment.

Key findings:

- Sexual health history-taking, STD counseling, screening/diagnosis and treatment are all covered at 98-99% across plans.

Core services coverage: STD screening, diagnosis and treatment.
99% of plans cover both core services. By plan type, coverage is as follows:

HMO – 100%
POS – 100%
PPO – 100%
Indemnity – 89%

99% of females in the 15 to 44 year age group and 99% of females 45-and-over have coverage of both core services. No significant difference exists in core coverage between 1998 and 2000.

Comparison to 1998 OIC Reproductive Health Benefits Survey:

- Coverage rates remain near 100%, either through routine or restricted coverage.

HIV

Service definition: HIV counseling and testing, HIV treatment, and full Rx formulary (protease inhibitors).

Key findings:

- HIV counseling/testing, treatment and full prescription drug formulary (including protease inhibitors) are all covered at or near 100%.

Core services coverage: Counseling, testing, treatment and full formulary.
99% of plans cover both core services. By plan type, coverage is as follows:

HMO – 100%
POS – 100%
PPO – 100%
Indemnity – 89%

99% of females in the 15-44 year age group and 100% of females 45-and-over have coverage of both core services. There is no significant change in core coverage between 1998 and 2000.

Comparison to 1998 OIC Reproductive Health Benefits Survey:

- Coverage rates for HIV counseling, testing and treatment essentially remain at 100%.
- Since the 1998 survey, coverage of full prescription drug formulary (including protease inhibitors) remains high, with an increase in coverage by POS plans in the 2000 survey. However, overall rates of coverage remain unchanged (95%) from 1998.

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OFFICE OF THE INSURANCE COMMISSIONER

WOMEN'S HEALTH BENEFITS SURVEY

Introduction

The Office of the Insurance Commissioner (OIC) regulates health insurance plans that directly affect the lives of 3,130,746 consumers, of whom approximately 1.6 million are women. Every year, OIC handles more than 200,000 consumer complaints and inquiries – a significant majority of which come from women. Women from all over the state of Washington call OIC with questions about their health care coverage, what is required of their insurance carriers, and in some cases they ask the OIC to intervene on their behalf with the insurance carrier.

These questions and complaints prompted OIC to conduct the 1998 Reproductive Health Benefits Survey. The survey reviewed the benefit coverage of services that are critical for the reproductive and sexual health of women, men and families. The survey described 91 top-selling plans with a combined enrollment of 1,399,650 individuals, from a market-representative sample of 12 health insurance carriers. OIC found wide variations in coverage of core services by plan type. For example, while the overall proportion of plans covering core gynecologic, maternity, reproductive cancer screening, STD and HIV/AIDS services was high, half of the plans (50%) did not cover any kind of contraceptive method. The OIC identified particular gaps in coverage for women's health benefits. The results of the survey were used by the Washington State Legislature to support various women's health policy initiatives.

Recent legislative history in Washington State provides further rationale for documenting women's health care needs includes. The Health Care Reform Act of 1993 included mandatory coverage for maternity and pregnancy termination, among other reproductive health services. In subsequent years, many sections of the act were repealed, leaving women without access to these necessary services.

Because OIC consults on proposed legislation, requests legislation, regulates the health insurance industry and is responsible for implementing legislation impacting the insurance industry, a complete picture of how health care is delivered in Washington is critical. Moreover, because women are the largest consumers of health care, a comprehensive profile of women's health care services will help guide the future of health care delivery in the state.

Survey Methodology

All eligible health insurance carriers in the state of Washington were identified as possible respondents for the survey. Carriers were designated as eligible if they were licensed health care service contractors (HCSCs) or health maintenance organizations (HMOs) and doing business in the state of Washington (but not necessarily domiciled in the state of Washington). Carriers were excluded from eligibility if they sold only Medicare managed care policies, because the data would not reflect the primary population of interest. During the time this survey was conducted, approximately 27 health insurance carriers were licensed to do business in Washington State. Twenty-five met inclusion criteria for the survey.

Carriers were asked to base responses to survey questions on their five best-selling group plans and their two best-selling individual plans. As with the 1998 survey, carriers were notified that the publicly-available technical report from the survey would include carrier and plan names.

In general, the 2000 survey tool was modeled after the 1998 survey tool. (Please see the Appendix for questions included in each survey section.) A major change to the 2000 survey was the deletion of any questions relating to coverage of services that would apply only to males. The 'reproductive cancer screening' section from the 1998 survey was changed to 'cancer screening' for the 2000 survey.

Sections added to the 2000 survey include preventive care, mental health and midlife health. The 'preventive health' section was added to the survey based on policy discussions relating to the preventive care philosophy of HMOs, juxtaposed with evolving financial difficulties in the managed care marketplace. In addition, this survey section was added to establish a baseline for coverage of preventive care. Questions relating to coverage of mental health services were added because of multiple legislative attempts in the state of Washington to mandate mental health benefits. The 'midlife health' section was added to the 2000 survey because of policy discussions about insurance coverage for women in the peri-menopausal and menopausal years.

Two sections from the 1998 survey - termination of pregnancy and sterilization – were not included in the 2000 survey. Questions relating to coverage for termination of pregnancy were excluded because with little to no change in federal or state laws, a significant change in coverage was not expected. (In the 1998 survey, all plans covered medically necessary procedures and 67% to 86% covered elective procedures.) The section relating to coverage of sterilization procedures was omitted from the 2000 survey because tubal ligation and hysterectomy were covered in 76% of the plans in 1998 and little change was expected. The rule to exclude questions relating to procedures exclusive to males was also factored into this decision.

The revised 2000 survey was beta-tested on two carriers. The final version was distributed to carriers in June 2000. Carriers had at least two weeks to answer survey questions. During the two week period, carriers were able to call or e-mail questions to the Project Manager at OIC. To enhance the quality of the data, the Project Manager and a clinical consultant (advisory group

member) met with carrier representatives to clarify questions and review answers. Data entry (into an Excel spreadsheet) was conducted in the presence of the carrier representatives. Carriers electronically received a file containing their data for review and comment. Narrative comments regarding discrepancies were submitted to OIC by e-mail; corrections were entered into the spreadsheet by the Project Manager; and a final check of the data was made by the carrier's representative, again by electronically submitted files. After this triple-check on data quality, data files were transferred to the data analyst.

Valid responses were received from all 25 carriers. The breakdown by carrier license included 75 Health Care Service Contractor plans, 32 Health Maintenance Organization plans and 7 insurance companies marketing Indemnity health insurance products.

The following carriers responded to the survey in the Fall of 2000:

- Aetna US Healthcare, Inc.
- Aetna US Healthcare of Washington, Inc.
- Aetna Life Insurance Co.
- Clark United Providers
- Community Health Plan of Washington
- First Choice Health Plan, Inc.
- Group Health Cooperative of Puget Sound
- Kaiser Foundation Health Plan of the Northwest
- Kaiser Permanente Health Alternative
- KPS Health Plans
- Molina Healthcare of Washington, Inc.
- Northwest Washington Medical Bureau
- ONE Health Plan of Washington, Inc.
- Options Health Care, Inc.
- PacifiCare of Washington, Inc.
- Premera Blue Cross
- Premera HealthPlus
- Providence Health Plan (Oregon)
- Regence BlueCross BlueShield of Oregon
- Regence Blue Shield
- Regence Northwest Health
- Regence Health Maintenance of Oregon
- RegenceCare
- United Healthcare of Washington, Inc.
- Virginia Mason Group Health Alliance

Initial responses were entered into an Excel database. Data quality was verified by a double-entry check of more than 20% of answers. A process for data analysis was developed and documented to ensure consistent treatment of the data across survey sections. Also, syntax was used whenever repeated commands were needed to transform data.

Descriptive statistics (frequencies) were reported for all survey questions. When questions were consistent and could be compared from 1998 to 2000, the Two-sample Test of Binomial Proportions was used (providing that data met the assumptions of the test) to test for the presence of a statistically significant difference between answers in the two surveys.

Survey Sample Description

In 2000, a follow-up survey was conducted. This survey included 114 top-selling plans from 25 different carriers.[1] Survey categories included:

- Gynecological care
- Maternity services
- Contraception and family planning
- Infertility
- Cancer screening
- Preventive care
- Mental health
- Midlife health
- Sexually transmitted diseases
- HIV

The 114 plans serve the following markets:

- 43.9% large and small group (n=50)
- 32.5% large group (n=37)
- 14.0% Indemnity (n=16)
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Plans by carrier license include:

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These plans represent coverage for a total of 1,821,417 lives, approximately 39% of which are female. There were 453,749 women (64%) in the 15 to 44 year age group and 256,798 (36%) in the 45-and-over age group.

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Respondents by plan types (organizational structure) include:

- 44.7% Primary care 'gatekeeper' or HMO-type managed care[2]
- 24.6% Point-of-service (POS)[3]
- 22.8% Preferred Provider Organization (PPO)[4]
- 7.9% Indemnity[5]

The number of enrollees in the surveyed plans represent 1,821,417 lives, with a breakdown by gender of 39% female and 61% male. The number of females in age group 15 to 44 total 453,749 (64%) and those in the 45-and-over age group number 256,798 (36%). Of the more than 1.8 million enrollees in surveyed plans, 44% (n=802,045) are in 'gatekeeper' managed care plans, 37% (n=667,370) are in PPOs, 15% (n=270,730) are in POS plans, and 4% (n=81,272) are in Indemnity plans (see Figure 2). This compares to results of the 1998 survey of 1,399,650 enrollees in the state of Washington, where 70% were in 'gatekeeper' managed care plans, 17% were in PPOs, 9% in POS plans, and 4% in Indemnity plans.

The data is reported as a combined figure that includes whether the service is covered routinely ('yes' without restrictions) or covered with restrictions.[6] Therefore, the term 'coverage' refers to coverage of any kind. Coverage is reported for every individual service in the section, as well as for overall coverage of the service by all carriers.

Figures represent only surveyed plans and are not to be considered representative of all Washington State health insurance plans.

[2] Enrollees in these plans must use a Primary Care Provider (PCP) for specialty referrals, using contracted providers. Coverage/coinsurance levels are usually based on whether a provider is in a network. In some plans, if an out-of-network provider is used, there is no coverage.

[3] 'POS' plans encourage, but do not require, enrollees to choose a primary care provider. Plan members may opt to use providers within the network. Enrollees may use non-preferred providers, but at a higher cost.

[4] 'PPOs' are health care arrangements that provide incentives to enrollees (such as lower deductibles and copays) to use providers within the their network. Enrollees may use non-preferred providers, but at a higher cost.

[5] 'Indemnity' plans traditionally reimburse the policyholder for incurred health care costs.

[6] Specific restrictions, such as age and monetary limits, are discussed in the full report.

Gynecological Care

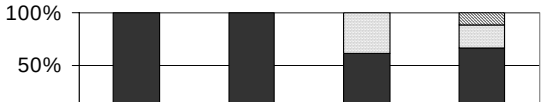
This section asked about coverage for annual exams, chlamydia screenings, annual and clinical breast exams, sexual dysfunction screenings, treatment and prescription drugs, and sexual health counseling.

Survey Findings

Please see Figure G-1 for a graphical overview of service coverage in each plan type. This figure identifies whether a service is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

Figure G-1: Gynecological Care, By Plan Type

Pap Smear

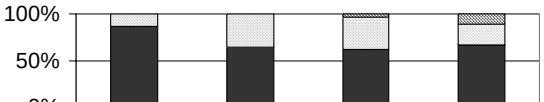


	HMO	POS	PPO	IND
No				11%
R			39%	22%
Yes	100%	100%	62%	67%

Chlamydia Screen

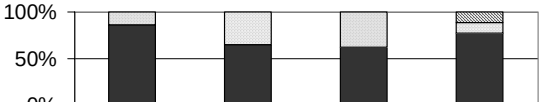
	HMO	POS	PPO	IND
No				11%
R			39%	22%
Yes	100%	100%	62%	67%

Annual Exam



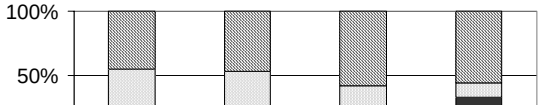
	HMO	POS	PPO	IND
No			4%	11%
R	14%	36%	35%	22%
Yes	86%	64%	62%	67%

Breast Exam



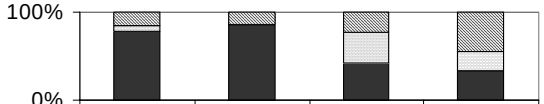
	HMO	POS	PPO	IND
No				11%
R	14%	36%	39%	11%
Yes	86%	64%	62%	78%

Sexual Dys Scr/Tx/Rx



	HMO	POS	PPO	IND
No	45%	46%	58%	56%
R	37%	32%	31%	11%
Yes	18%	21%	12%	33%

Sexual Health Counseling



	HMO	POS	PPO	IND
No	16%	14%	23%	44%
R	6%		35%	22%
Yes	78%	86%	42%	33%

Total Coverage (Routine plus Restricted Responses)

Pap smears, chlamydia screening, annual exams and clinical breast exams essentially are covered at 100%. (The only 'N' answers are from the PPO plan and the Indemnity plan that are no longer sold.) About one-half of the plans, regardless of type, provide coverage for sexual dysfunction exams, although most with restrictions. The majority of plans cover sexual health counseling.

Restrictions

Restrictions on preventive (screening) exams generally are based on age or frequency recommendations, either through the plan's own guidelines or through national guidelines. Some plans include a sexual health or dysfunction exam as a part of an overall preventive health exam. In some plans, sexual dysfunction exams are covered, but drugs for treatment of sexual dysfunction are not covered unless a prescription drug rider is purchased by the subscriber.

Rider/Age Restrictions/Direct Access/Copayment

The majority of plans that cover these services do so as a part of the basic benefit rather than as a separate option or rider. Of those plans that offer all or part of these benefits as a rider, 65% or more of the enrollees have the benefit. Age restrictions were in place in 7 of the 51 (13.7%) of HMO plans and 6 of 28 (21.4%) POS plans. Restrictions in the HMO plans related to the frequency of preventive exams by age group and the start of annual and clinical breast exam baselines at age 40. One POS plan provided for a preventive exam every 4 to 5 years in age groups 20-49 with no co-pay, while annual exams would be covered with a co-pay. The remaining POS plans set age 40 as the age at which annual and clinical breast baseline exams would be covered. No age restrictions were imposed in either the PPO or Indemnity plans. As required by law, all plans allow women direct access to these services. Most plans require co-payments for services. By plan type, those that do not require co-payments are as follows: HMO – 13.7%; POS – 17.9%; PPO – 15.4%; and Indemnity – 11.1%.

Comparison to 1998 OIC Reproductive Health Benefits Survey

Coverage rates remain high for Pap smears, chlamydia screening, mammograms, annual exams and clinical breast exams. Coverage in 2000 for sexual health counseling appears to have decreased when compared to coverage rates in 1998, but the difference is not statistically significant. No comparison is possible for sexual dysfunction exams, as this category was not included in the 1998 survey. (See Figure G-2). No statistically significant difference exists in coverage of core services between 1998 and 2000. (See Figure G-3).

Figure G-2. Comparison of coverage for Gynecological Care between 1998 and 2000 (percent 'yes').

	HMO (%)		POS (%)		PPO (%)		Indemnity (%)		Overall coverage (%)	
	n=49	n=51	n=15	n=28	n=20	n=26	n=7	n=9	n=91	n=114
	1998	2000	1998	2000	1998	2000	1998	2000	1998	2000
Pap smear	96	100	100	100	72	100	100	89	*92*	*99*
Chlamydia	96	100	100	100	72	100	100	89	*92*	*99*
Annual Exam	96	100	100	100	72	97	100	89	*92*	*98*
Breast Exam	96	100	100	100	72	100	100	89	*92*	*99*
Sex Health C.	89	84	84	86	78	77	100	66	**88**	**81**

'Overall coverage' results in italics were not submitted to tests of difference because difference in coverage is too small to meet statistical assumptions of test. 'Overall coverage' results in bold were submitted to the Two-sample Test for Binomial Proportions. There was no statistically significant difference between coverage for Sexual Health Counseling in 1998 and 2000.

Figure G-3. Comparison of coverage of core services between 1998 and 2000 (Pap smear, chlamydia screening, clinical breast exam, annual exam, mammography); percent and number of females 15-44 years of age and females 45 and over with coverage for all five core services.

	1998	2000		
	(%)	(%)	Females 15-44	Females 45 and over
All plan types	92	91	91% (410,720)	91% (234,777)
HMO	96	100	100% (195,414)	100% (95,985)
POS	100	100	100% (75,843)	100% (39,455)
PPO	72	69	76% (126,491)	81% (85,183)
Indemnity	100	78	78% (12,972)	87% (14,154)

Maternity Services

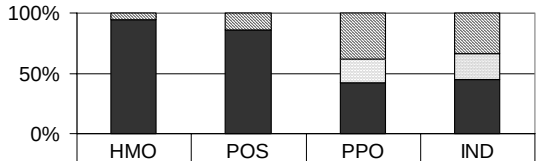
This section of the survey asked questions about coverage for preconceptual counseling, prenatal testing, prenatal care, prenatal vitamins and supplements, hospital, home and birth unit delivery, delivery by certified nurse midwife, postpartum care, newborn care, 21-day postpartum care of the child of a dependent, and prenatal care of teen dependents.

Survey Findings

Please see Figure M-1 for a graphical overview of service coverage in each plan type. This figure identifies whether a service is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

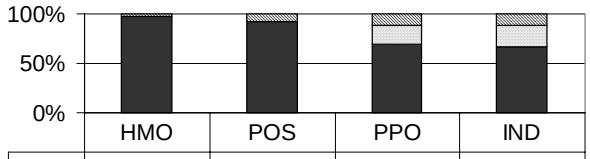
Figure M-1: Maternity Services by Plan Type

Preconceptual Counseling



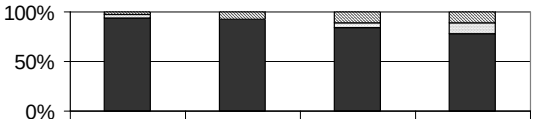
	HMO	POS	PPO	IND
No	6%	14%	39%	33%
R			19%	22%
Yes	94%	86%	42%	44%

Prenatal Testing



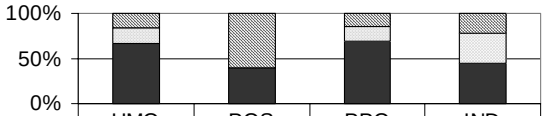
	HMO	POS	PPO	IND
No	2%	7%	12%	11%
R			19%	22%
Yes	98%	93%	69%	67%

Prenatal/OB Care



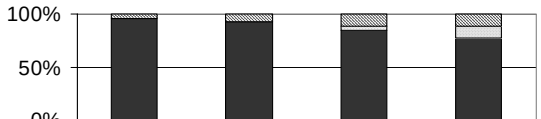
	HMO	POS	PPO	IND
No	2%	7%	12%	11%
R	4%		4%	11%
Yes	94%	93%	85%	78%

Prenatal Vits/Supps



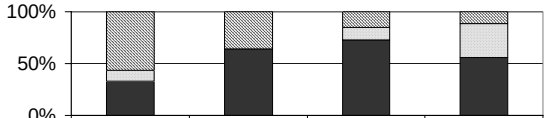
	HMO	POS	PPO	IND
No	16%	61%	15%	22%
R	18%		15%	33%
Yes	67%	39%	69%	44%

Hospital Delivery

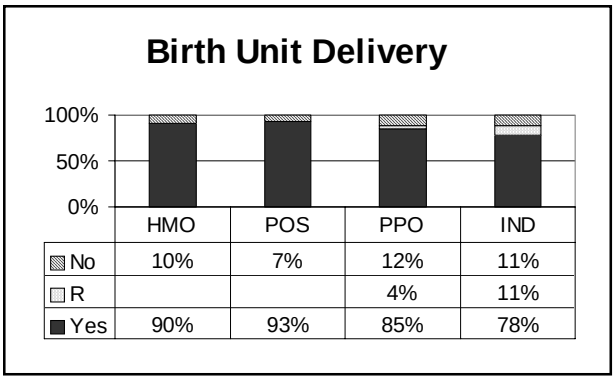


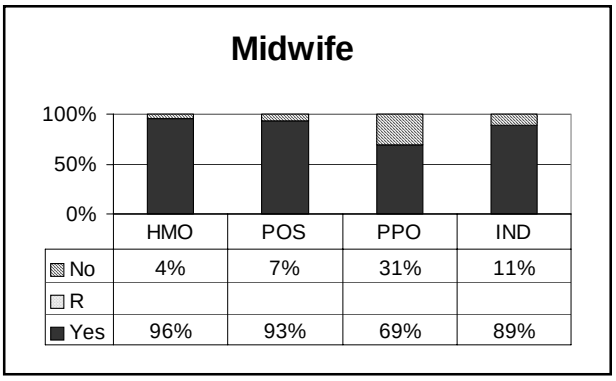
	HMO	POS	PPO	IND
No	4%	7%	12%	11%
R			4%	11%
Yes	96%	93%	85%	78%

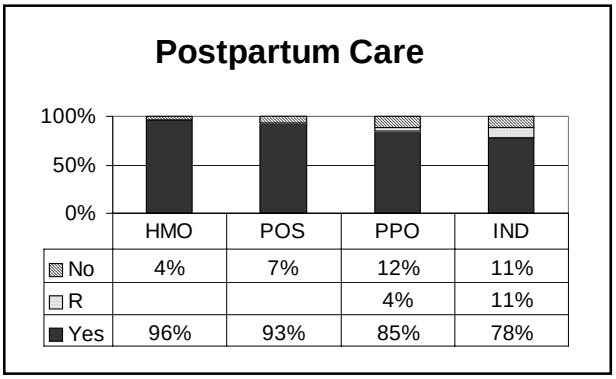
Home Delivery

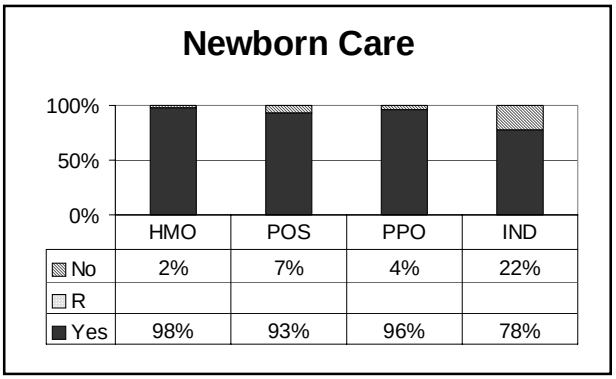


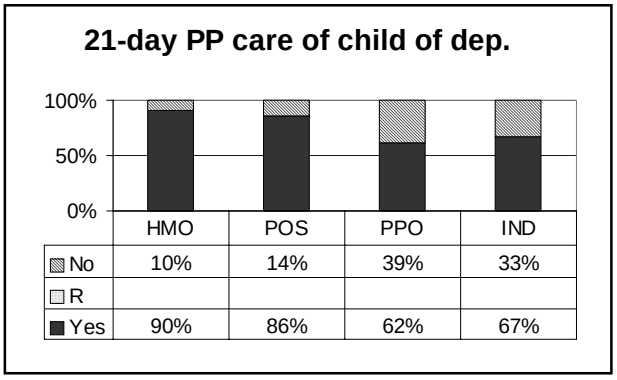
	HMO	POS	PPO	IND
No	57%	36%	15%	11%
R	10%		12%	33%
Yes	33%	64%	73%	56%

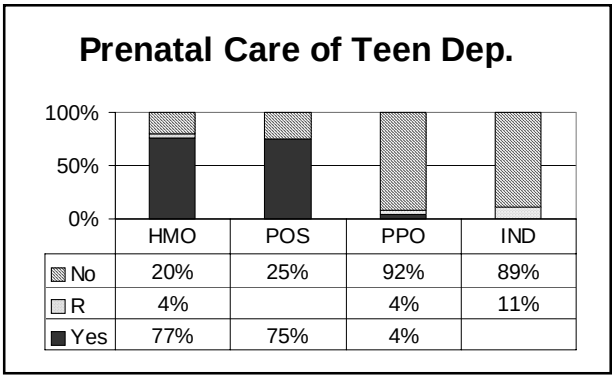












Total Coverage (Routine plus Restricted Responses)

The majority of HMO (94%) and POS (86%) plans cover preconceptual counseling without restriction. Routine plus restricted responses indicate that 61% of responding PPOs and 66% of Indemnity plans cover this service. Almost all plans surveyed cover prenatal testing, prenatal care, hospital delivery, birth unit delivery, postpartum care and newborn care.

Coverage for prenatal vitamins and supplements varies, with relatively high rates of coverage in HMO, PPO and Indemnity plans, and relatively low rates in the POS plans. Home delivery coverage is highest in PPO and Indemnity plans and lowest in the HMO plans. Coverage for delivery by midwives ranges from 69% in PPOs to 96% in HMOs. Newborn care coverage is relatively high among plans. Plan coverage for 21-day postpartum care of the child of a dependent is in the 62% to 67% range for PPOs and Indemnity plans, and in the 86% to 90% range for HMO and POS plans. There are marked differences among plans in coverage for prenatal care of a teen dependent: 75% to 80% for HMO and POS plans and 8% to 11% for PPO and Indemnity plans.

In looking at coverage of core maternity services (i.e., prenatal testing and care, hospital delivery, postpartum care and newborn care), 96-98% of HMOs and 93% of POS plans provide coverage (routine plus restricted responses). Eighty-nine percent of PPOs cover the core services, while only 78% of Indemnity plans provide these services.

Restrictions

Across plan types, there are no restrictions on the number of births covered, and most plans offer these services as a basic benefit. Only 3.9% of HMO and 10.7% of POS plans cover these benefits through a rider.

Most plans cover preconceptual counseling as a part of the normal office visit and bill as such. As a part of prenatal testing, elective gender typing is not covered in any of the plans. In some plans, newborn care is covered for the subscriber and dependents for 31 days. Coverage for midwife services in some plans is restricted to a requirement that delivery take place in a licensed facility. Five plans require prior authorization for delivery in a birthing facility. In some plans, coverage for home delivery service is limited to the scope of services within the professional's license.

Maternity coverage is restricted by some plans to only the female subscriber and her spouse. Prenatal care of teen dependents is restricted to large group plans by some carriers, while small group plans in these companies cover only the subscriber and spouse. In some cases, 21-day coverage of a child of a dependent is driven by whether or not the mother has coverage. Certain plans cover only maternity services if conception occurred while covered by the plan and/or if the mother has been continually enrolled since conception. Subsidized Basic Health Plan members have 30 days of maternity coverage from the time of diagnosis, at which time their coverage changes to Healthy Options. The only dollar-limit on coverage was noted for a plan that is no longer for sale.

Rider/Wait Period/Direct Access/Copayment

Most prenatal vitamins and supplements are covered under a prescription drug rider. In some plans enrollees may purchase a rider that excludes co-pays for preventive, prenatal, and postnatal care. All women have direct access to providers for maternity services. There are no benefit waiting periods among HMO and POS plans, while 7.7% of PPO and 33.3% of Indemnity plans have benefit waiting periods. Certain plans only require one co-pay per pregnancy – the co-pay for the first visit.

Comparison to 1998 OIC Reproductive Health Benefits Survey

See Figures M-2 and M-3. Across all plan types, coverage for preconceptual care has risen. The increase in coverage approaches, but does not attain, statistical significance. Coverage for prenatal testing, prenatal care, and hospital delivery are, overall, relatively unchanged among plans from 1998 to 2000. (There is a slight decrease in coverage of these services among PPO plans.)

Home Delivery coverage has declined in HMO, PPO and Indemnity plans since 1998, with only POS plans showing an increase from 53% coverage in 1998 to 64% coverage in 2000. **Overall, coverage for home delivery (76% in 1998 and 61% in 2000) had a statistically significant decrease (p=.04) over the two-year period**.

Birth unit delivery coverage has increased slightly among HMO plans since 1998, while PPO and Indemnity coverage has decreased and POS coverage has remained about the same. Overall, however, there is no statistically significant difference in coverage for this service from 1998 to 2000.

Postpartum care coverage rates remain about the same. Newborn care coverage has decreased among Indemnity plans from 100% coverage in the 1998 survey to only 78% coverage reported in the 2000 survey. However, the two Indemnity plans that no longer provide this coverage also are no longer for sale. No statistically significant difference exists in the coverage of core services from 1998 to 2000.

The following services were not included in the 1998 survey, and were therefore not available for comparison: prenatal vitamins/supplements, midwife services, 21-day postpartum care of the child of a dependent, and prenatal care of teen dependents.

Figure M-2: Comparison of coverage for Maternity Services between 1998 and 2000 (percent 'yes').

	HMO (%)		POS (%)		PPO (%)		Indemnity (%)		Overall coverage (%)	
	n=49	n=51	n=15	n=28	n=20	n=26	n=7	n=9	n=91	n=114
	1998	2000	1998	2000	1998	2000	1998	2000	1998	2000
Prec. Counsel	82	94	62	86	76	61	28	66	**73**	**82**
Prenatal Test	100	98	92	93	94	88	86	89	*97*	*94*
Prenatal Care	100	98	92	93	94	88	86	89	*97*	*94*
Hospital Del	95	96	92	93	94	88	86	89	**95**	**93**
Home Del	69	43	53	64	100	85	100	89	**76**	**61**
Birth Un. Del	84	90	93	93	94	88	100	89	**89**	**90**
Postpartum	100	96	92	93	94	88	86	89	*97*	*93*
NewbornCare	100	98	92	93	94	96	100	78	*98*	*95*

'Overall coverage' results in italics were not submitted to tests of difference because difference in coverage is too small to meet statistical assumptions of test. 'Overall coverage' results in bold were submitted to the Two-sample Test for Binomial Proportions.

Figure M-3: Comparison of coverage of core services between 1998 and 2000 (prenatal testing and care, hospital delivery, postpartum and newborn care); percent and number of females 15-44 years of age and females 45 and over with coverage for all five core services.

	1998	2000		
	(%)	(%)	Females 15-44	Females 45-and-over
All plan types	93	92	95% (433,305)	91% (241,713)
HMO	93	96	99% (192,946)	98% (94,260)
POS	92	93	91% (68,870)	82% (32,467)
PPO	94	89	96% (158,517)	96% (100,832)
Indemnity	86	78	78% (12,972)	87% (14,154)

Contraception/Family Planning

This section asked questions relating to contraception and family planning service coverage. Specifically, carriers were asked to identify coverage for contraceptive counseling, over-the-counter contraceptives, IUDs (device, insertion, removal), diaphragms (device and cap fit), Norplant (device, insertion and removal), DMPA injection, oral contraceptive pills, emergency contraception, prescription drug benefit as part of the plan and whether or not contraceptives are part of this benefit.

Survey Findings

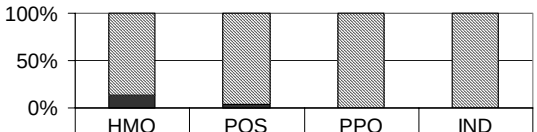
Please see Figure C-1 for a graphical overview of service coverage in each plan type. This figure identifies whether a service is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

Figure C-1: Contraception/Family Planning Service Coverage, by Plan Type

Contraceptive Counseling

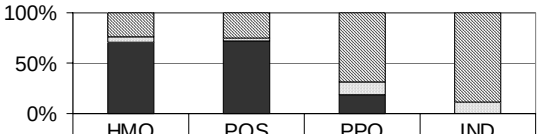
	HMO	POS	PPO	IND
No	6%	14%	31%	33%
R	4%	4%	39%	
Yes	90%	82%	31%	67%

OTCs



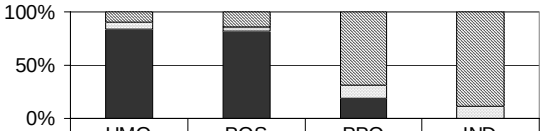
	HMO	POS	PPO	IND
No	86%	96%	100%	100%
R				
Yes	14%	4%		

Intrauterine Device



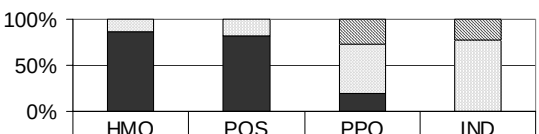
	HMO	POS	PPO	IND
No	24%	25%	69%	89%
R	6%	4%	12%	11%
Yes	71%	71%	19%	

IUD Insertion



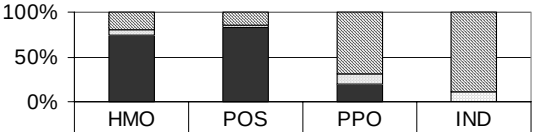
	HMO	POS	PPO	IND
No	10%	14%	69%	89%
R	6%	4%	12%	11%
Yes	84%	82%	19%	

IUD Removal

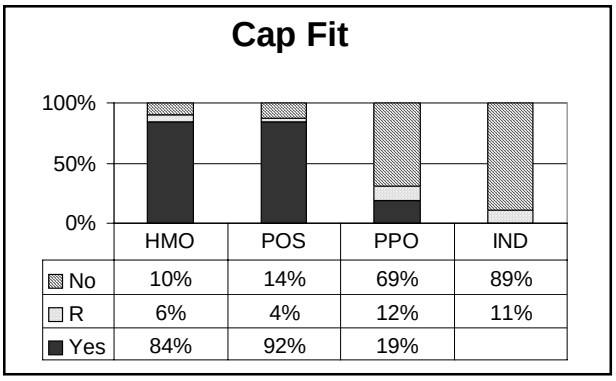


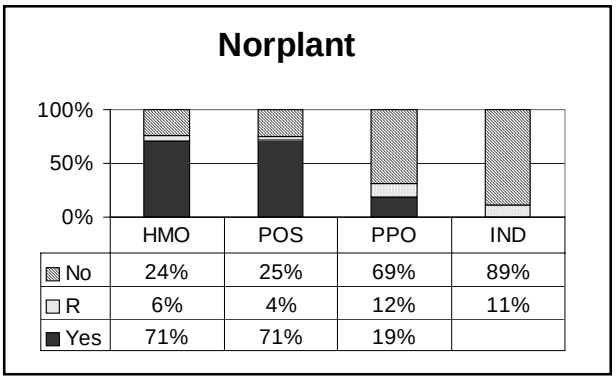
	HMO	POS	PPO	IND
No			27%	22%
R	14%	18%	54%	78%
Yes	86%	82%	19%	

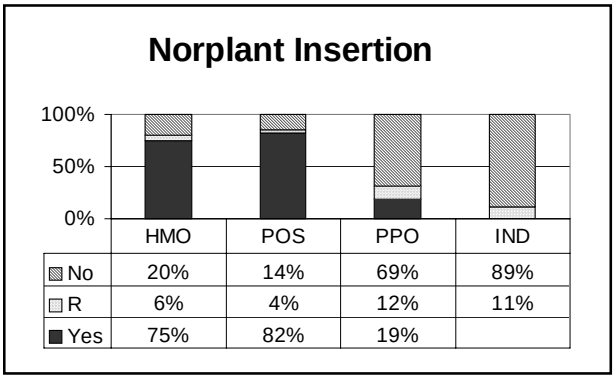
Diaphragm

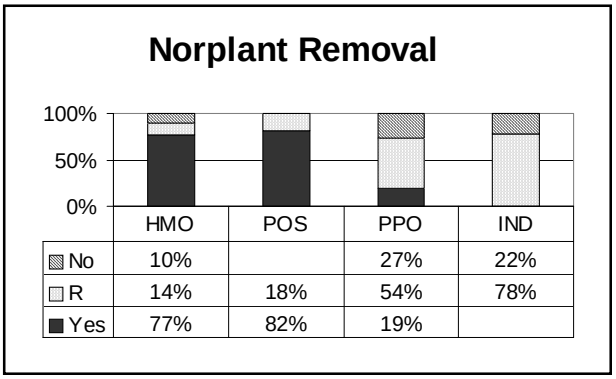


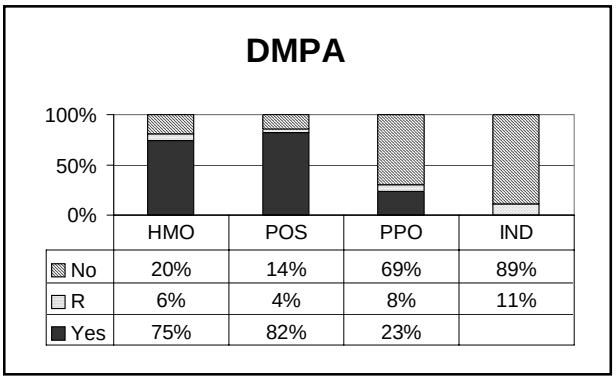
	HMO	POS	PPO	IND
No	20%	14%	69%	89%
R	6%	4%	12%	11%
Yes	75%	82%	19%	

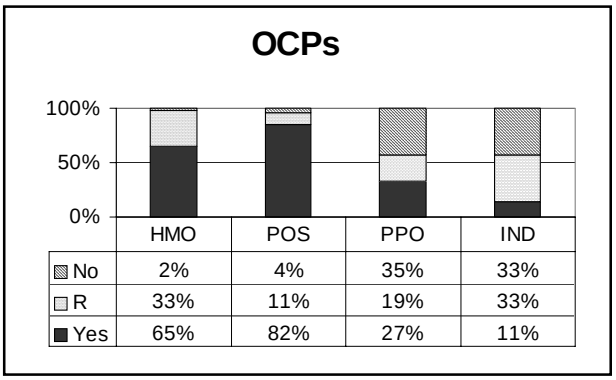


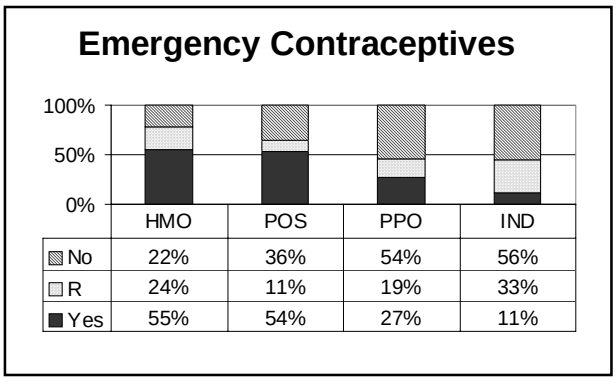












Total Coverage (Routine plus Restricted Responses)

Coverage rates for contraceptive counseling are high among HMO and POS plans at 94% and 86% respectively. PPO plans cover this service at 70%, while 67% of Indemnity plans provide coverage. Over-the-counter contraceptives are only covered at 14% in HMO plans and 4% in POS plans, while there is no coverage through PPO or Indemnity plans.

HMO and POS plans provide high (and similar, if not identical) rates of coverage for intrauterine devices, insertion and removal, diaphragm devices and cap fit, and Norplant devices, insertion and removal. PPO coverage rates for IUDs and insertion, diaphragms and cap fits, and Norplant and insertion are lower (31%), with Indemnity plans being the lowest, providing coverage in only 11% (1 out of 9) of reported plans in the survey. Most, if not all, reporting HMO and POS plans pay for the removal of IUDs and/or Norplant, along with 73% of PPOs and 78% of Indemnity plans.

DMPA injections are covered by 81% to 86% of HMO and POS plans, while only 31% of PPO and 11% of Indemnity plans provide coverage. Oral contraceptive pills are covered by 98% and 93% of HMO and POS plans respectively, with much lower coverage rates by PPOs and Indemnity plans.

The majority of HMO and POS plans included in the survey provide coverage for emergency contraception, while the majority of PPO and Indemnity plans do not.

Restrictions

In some plans, contraceptive counseling is only covered if it is part of a routine medical office visit. In other plans, counseling is covered if an enrollee purchased a prescription drug rider. Many plans restrict IUD and Norplant removal to medical conditions only. Some plans that cover OTCs (spermicides and condoms) and oral contraceptive pills require a prescription and restrict selection to items in the formulary. Oral contraceptive pills may be obtained for more than one month in 57% of HMOs, 89% of POS plans, 31% of PPOs and 33% of Indemnity plans. Of those that do allow more than one month of OCPs, enrollees may purchase up to a 3-month supply at a time. Some plans allow a one-month vacation override, but enrollees may only use the override once per year.

Rider/Direct Access/Copayment

Most prescription drug coverage requires a prescription drug rider, but not all such riders include coverage for OCPs. PPO (77%) and Indemnity plans (89%) exclude OCPs from the prescription drug rider benefit more often than HMO and POS plans, which exclude OCPs from 37% and 28% of the prescription drug riders. Plans report that between 60% and 98% of their subscribers purchase a prescription drug rider. At times, contraceptive coverage is dependent on the purchase of a rider by the group, with benefits varying by group size. For example, groups with 1-99 members can get coverage for OCPs and diaphragms/cervical cap fit, but groups with more than 100 members have the option of all FDA-approved contraceptive devices. Some plans also report that IUD, Norplant and cervical cap/diaphragm device insertion and fitting are restricted to a contraceptive benefit, which 30% to 98% purchase.

One-hundred percent of HMOs and 93% of POS plans allow direct access to providers for contraceptive/family planning services. Only 65% of PPOs and 56% of Indemnity plans do so. The majority of HMO, POS and Indemnity plans require a co-pay, while PPO plans are evenly split between requiring and not requiring co-pays. Co-pays vary depending on the product or service.

Comparison to 1998 OIC Reproductive Health Benefits Survey

See Figures C-2 and C-3. All plans in the 2000 survey show an increase in coverage for contraceptive and family planning services over the services graphed in the 1998 OIC Reproductive Health Benefits Survey. (See Figure C-2). Using the Two-sample Test for Binomial Proportions, the increases are highly statistically significant ($p<.01$) or very highly statistically significant ($p<.001$) for all services except OTCs, where the difference was not big enough to meet the assumptions of the test for significance. The increase in coverage of core services (from 30% in 1998 to 54% in 2000) is highly statistically significant a $p<.001$.

Figure C-2: Comparison of contraceptive coverage by plan type in 1998 and 2000 surveys.

	HMO (%)		POS (%)		PPO (%)		Indemnity (%)		Overall Coverage (%)	
	n=49	n=51	n=15	n=28	n=20	n=26	n=7	n=9	n=91	n=114
	1998	2000	1998	2000	1998	2000	1998	2000	1998	2000
Counsel ****	82	94	54	86	28	70	14	67	**60**	**84**
OTCs	5	14	0	4	0	0	0	0	*2*	*7*
IUDs ****	70	77	62	75	6	31	0	11	**48**	**76**
Diaphragm**	70	80	38	86	6	31	0	11	**45**	**65**
Norplant***	52	77	30	75	6	21	0	11	**34**	**60**
DMPA**	59	81	62	86	6	31	0	11	**43**	**65**
OCPs**	84	98	92	93	11	46	0	44	**63**	**81**
Emer Con****	41	79	38	65	6	46	0	44	**30**	**65**

**p<.01 ***p<.001 ****p<.0001 'Overall coverage' results in italics were not submitted to tests of difference because difference in coverage is too small to meet statistical assumptions of test. 'Overall coverage' results in bold were submitted to the Two-sample Test for Binomial Proportions. 'Overall coverage' results shaded are statistically significant at the levels indicated by the asterisks.

Figure C-3: Comparison of coverage of core services between 1998 and 2000 (IUD, diaphragm, Norplant, DMPA and oral contraceptive pills); percent and number of females 15-44 years of age and females 45 and over with coverage for all core services. (See legend above)

	1998	2000		
	(%)	(%)	Females 15-44	Females 45 and over
All plan types***	**30**	**54**	69% (312,629)	70% (178,771)
HMO	50	66	87% (169,687)	87% (83,323)
POS	15	73	40% (30,361)	38% (14,878)
PPO	6	27	61% (101,393)	66% (69,441)
Indemnity	0	11	67% (11,188)	69% (11,129)

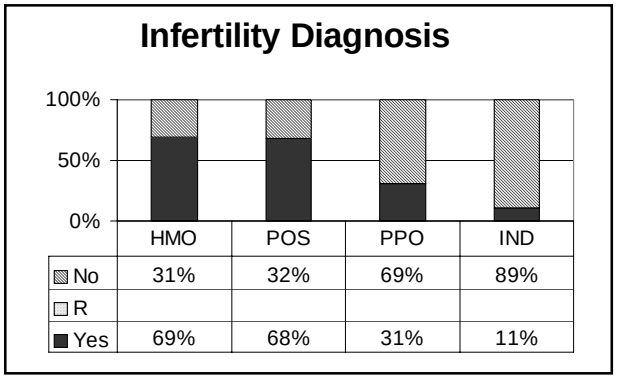
Infertility

Questions in this section of the survey asked carriers for information about coverage for infertility diagnosis or treatment, endometrial biopsy, treatment of endometreosis, and assisted reproductive technologies.

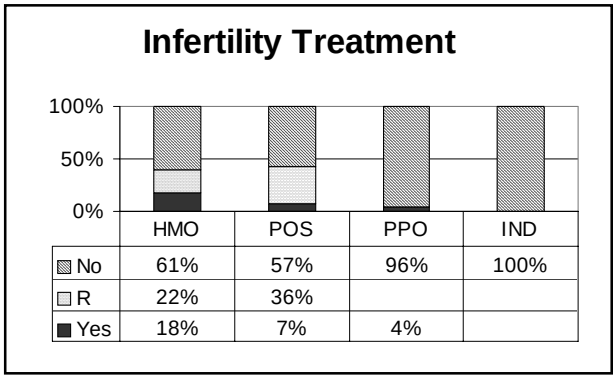
Survey findings

Please see Figure I-1 for a graphical overview of service coverage in each plan type. This figure identifies whether a service is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

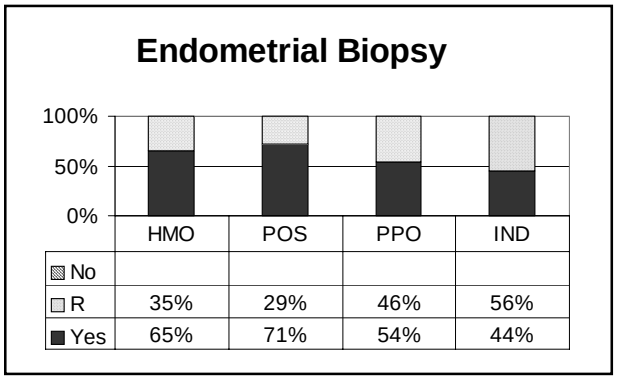
Figure I-1: Infertility Service Coverage, by Plan Type



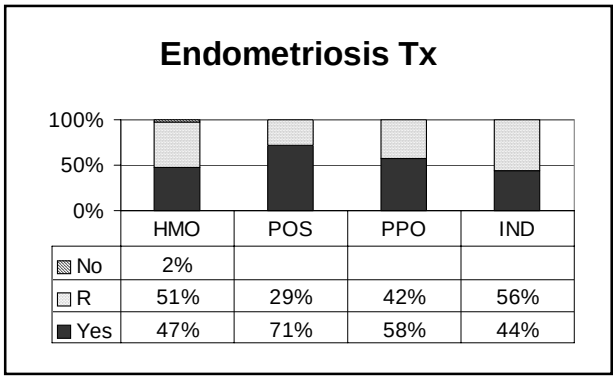
	HMO	POS	PPO	IND
No	31%	32%	69%	89%
R				
Yes	69%	68%	31%	11%



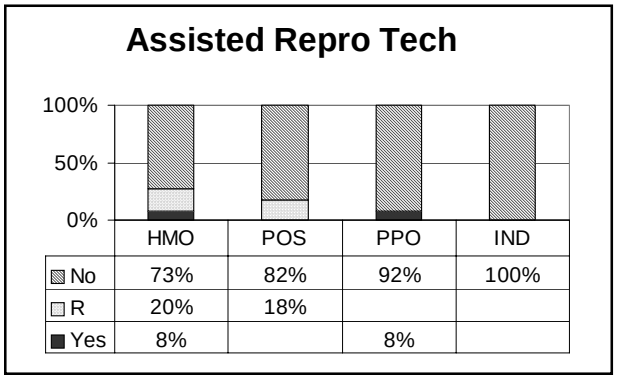
	HMO	POS	PPO	IND
No	61%	57%	96%	100%
R	22%	36%		
Yes	18%	7%	4%	



	HMO	POS	PPO	IND
No				
R	35%	29%	46%	56%
Yes	65%	71%	54%	44%



	HMO	POS	PPO	IND
No	2%			
R	51%	29%	42%	56%
Yes	47%	71%	58%	44%



	HMO	POS	PPO	IND
No	73%	82%	92%	100%
R	20%	18%		
Yes	8%		8%	

Total Coverage (Routine plus Restricted Responses)

Coverage for infertility diagnosis is available in about two-thirds of HMO and POS plans, while very few PPO and Indemnity plans cover this service. Many plans cover diagnosis but not treatment of infertility. Only 40 to 42% of HMO and POS plans cover infertility treatment, while only 4% of PPO plans and no Indemnity plans provide coverage. Some coverage for infertility treatment is limited to counseling. All plans reported in this survey cover endometrial biopsy and almost all plans cover endometriosis treatment. Only a few HMO, POS and PPOs plans provide coverage (mostly with restrictions) for Assisted Reproductive Technologies.

Restrictions

In many plans, endometriosis is covered as a medical condition, but not for the purposes of becoming pregnant. Some plans restrict what is covered as a part of infertility benefits. For example, some plans do not cover ZIFT, GIFT, ovum transplants or in-vitro fertilization as part of infertility benefits. Some plans limit infertility 'treatment' to counseling only and provide no coverage for infertility drugs.

Rider/Wait Period/Age Restrictions/Direct Access/Copayment

Many infertility benefits are covered only if a rider is purchased, including coverage for ARTs. Some ARTs are restricted to non-experimental or non-investigational procedures, and also require a referral from a primary care physician. In some cases, infertility treatment is restricted to an in-network basis. Coverage of infertility drugs are, in some plans, only covered if the subscriber has a prescription drug benefit. The majority of plans do not require a waiting period to be eligible for benefits, and no plans have an age restriction. Most enrollees (from 61% to 80%) have direct access. Most plans have co-pays, which vary depending on the product and service. Two carriers reported that in one of their plans, certain infertility services are covered, but subject to a 50% co-pay.

Comparison to 1998 OIC Reproductive Health Benefits Survey

See Figures I-2 and I-3. HMOs were the only plan type for which infertility diagnosis coverage improved over 1998 rates. All other plan types decreased coverage for this service. Overall, there is no statistically significant change in coverage rates for diagnosis of infertility between 1998 and 2000. In coverage of core services (infertility diagnosis and treatment), the 4% increase is statistically significant at $p<.05$.

Coverage for treatment of infertility increased in HMO and POS plan types, but fell in PPO and Indemnity plans. Only one PPO and no Indemnity plans cover infertility treatment, according to 2000 survey results. The overall change in coverage of these services is not statistically significant.

All surveyed plans now cover endometrial biopsy, although some coverage is with restriction. This is a very highly statistically significant change ($p<.0001$) from the 1998 survey, in which 50% to 86% of plans offered this type of coverage.

Coverage rates for treatment of endometriosis remain high across both surveys. In 2000, HMO and POS coverage rates have risen slightly, while PPO and Indemnity plans continue to cover this service at 100%, again with some restrictions. This category did not meet the statistical assumptions of the Two-sample test for Binomial Proportions and, therefore, no test was conducted.

The rate of coverage for ARTs remains low at 18% overall, but is improved over the complete lack of coverage across plans in 1998. This increase is very highly statistically significant at p<.0001.

Figure I-2: Comparison of Infertility Services by plan type in 1998 and 2000 surveys.

	HMO (%)		POS (%)		PPO (%)		Indemnity (%)		Overall Coverage (%)	
	n=49	n=51	n=15	n=28	n=20	n=26	n=7	n=9	n=91	n=114
	1998	2000	1998	2000	1998	2000	1998	2000	1998	2000
Infertility Dx	38	69	84	68	50	31	85	11	**53**	**55**
Infertility Tx	20	4	08	43	28	4	86	0	**25**	**29**
Endo Bx****	52	100	77	100	50	100	86	100	**58**	**100**
Endo Tx	86	98	93	100	100	100	100	100	*91*	*99*
ART****	0	28	0	18	0	8	0	0	**0**	**18**

*p<.05 **p<.01 ***p<.001 ****p<.0001 'Overall coverage' results in italics were not submitted to tests of difference for failure to meet statistical assumptions of test. 'Overall coverage' results in bold were submitted to the Two-sample Test for Binomial Proportions. 'Overall coverage' results that are shaded are statistically significant at the levels indicated by the asterisks.

Figure I-3: Comparison of coverage of core services between 1998 and 2000 (Infertility diagnosis and treatment); percent and number of females 15-44 years of age and females 45 and over with coverage for all core services. (See legend above)

	1998	2000		
	(%)	(%)	Females 15-44	Females 45 and over
All plan types*	**25**	**29**	20% (90,327)	20% (50,439)
HMO	8	39	50% (47,720)	31% (29,894)
POS	20	43	30% (22,991)	26% (10,304)
PPO	28	4	12% (19,616)	10% (10,241)
Indemnity	86	0	-	-

Cancer Screening

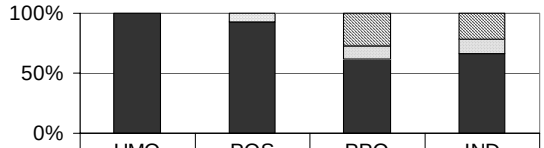
In this section of the survey, carriers were asked to identify coverage for the following cancer screening tests: Pap screens, HPV screens, colposcopy, fecal occult blood tests, flexible sigmoidoscopy and mammography. They were also asked to provide information about coverage for mastectomy or lumpectomy for breast cancer and breast reconstruction following either of these surgeries.

Survey Findings

Please see Figure CS-1 for a graphical overview of service coverage in each plan type. This figure identifies whether a service is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

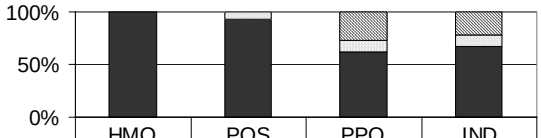
Figure CS-1: Reproductive Cancer Service Coverage, by Plan Type

Pap Screen



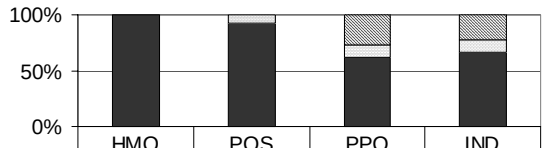
	HMO	POS	PPO	IND
No			27%	22%
R		7%	12%	11%
Yes	100%	93%	62%	67%

HPV



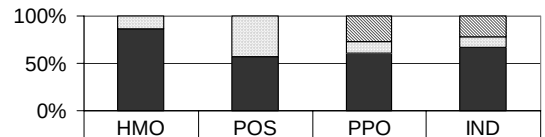
	HMO	POS	PPO	IND
No			27%	22%
R		7%	12%	11%
Yes	100%	93%	62%	67%

Colposcopy



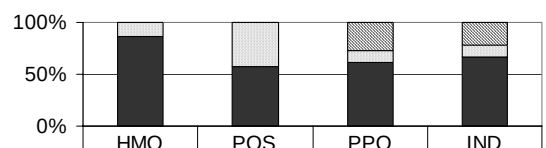
	HMO	POS	PPO	IND
No			27%	22%
R		7%	12%	11%
Yes	100%	93%	62%	67%

Fecal Occult Blood



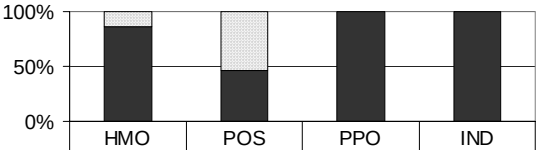
	HMO	POS	PPO	IND
No			27%	22%
R	14%	43%	12%	11%
Yes	86%	57%	62%	67%

Flex Sigmoidoscopy

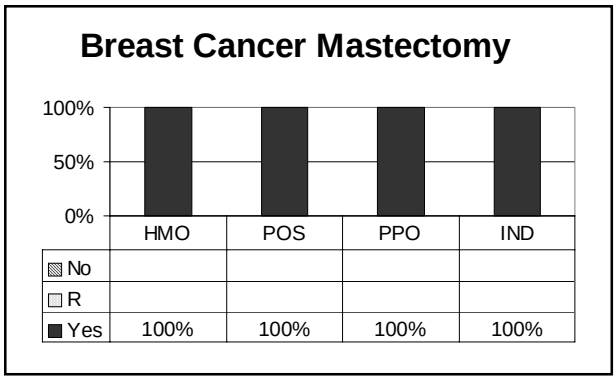


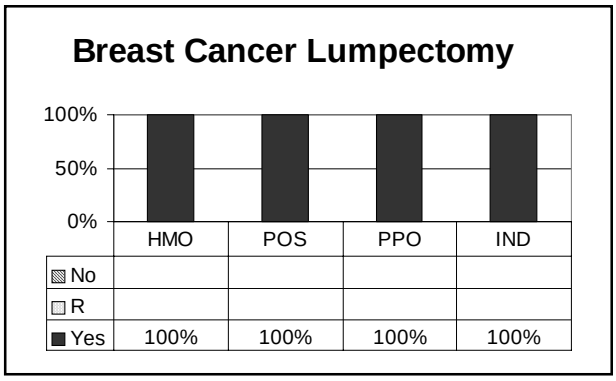
	HMO	POS	PPO	IND
No			27%	22%
R	14%	43%	12%	11%
Yes	86%	57%	62%	67%

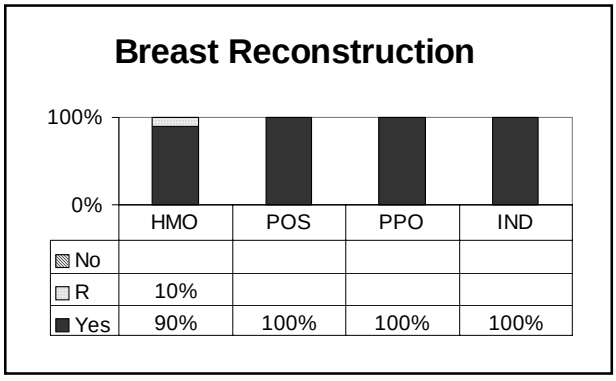
Mammography

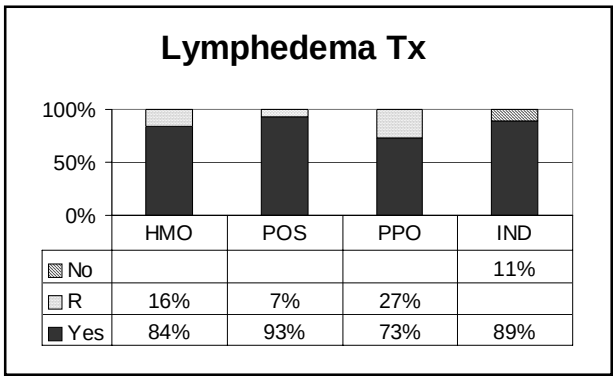


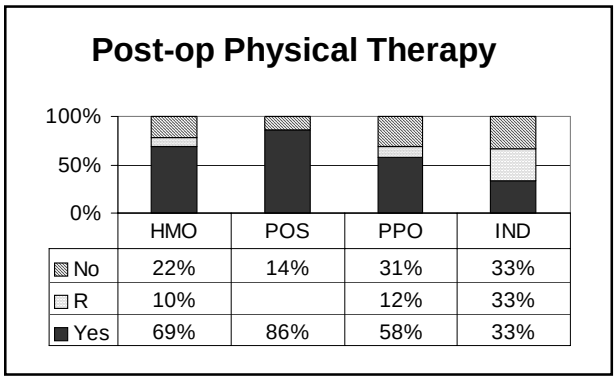
	HMO	POS	PPO	IND
No				
R	14%	54%		
Yes	86%	46%	100%	100%











Total Coverage (Routine plus Restricted Responses)

Coverage rates for Pap screen, HPV screening, colposcopy, fecal occult blood, and flexible sigmoidoscopy are the same, ranging from 78% in Indemnity plans and 74% in PPOs to 100 % (some with restrictions) in HMO and POS plans. Mammography, breast cancer mastectomy and lumpectomy, and breast reconstruction are covered (routine plus restricted responses) at 100% across all plans. Lymphedema treatment is covered at 100% except in Indemnity plans, where 89% of subscribers have coverage. Post-operative physical therapy is covered at a variable rate across plans, ranging from 66% in Indemnity plans to 86% in POS plans.

Restrictions

Restrictions for screening tests generally relate to age. For example, in some plans, flexible sigmoidoscopy and tests for fecal occult blood are covered, regardless of age, if the patient is symptomatic. If, however, the tests are solely for screening purposes, the tests are covered only if the patient is over age 50. Restrictions on coverage of mammograms relate to age at the time of baseline exam and to the frequency at which these tests are covered when the patient is between 40 and 50 years of age. In five of the managed care plans, lymphedema treatment is only covered

under a physical therapy benefit. Coverage of massage therapy for lymphedema is restricted to massage therapists who have specific training in this type of treatment. Two PPO and two Indemnity plans require that physical therapy for lymphedema treatment be part of a physician's formal treatment program to restore or improve lost function. In some plans, physical therapy requires a PCP referral.

Rider/Direct Access/Copayment

Only 27% of PPO and 36% of POS plans require a rider for cancer screening or treatment services. None of the HMO or Indemnity plans require a rider for these services. In several plans, coverage for screening tests requires purchase of a preventive care rider, unless the tests are done to diagnosis or rule out a medical condition. All patients have direct access to the services in this section of the survey. While most plans (89% to 100%) require a co-pay, many waive co-pays if preventive care is part of a preventive care schedule. Some co-pays vary depending on products and services.

Comparison to 1998 OIC Reproductive Health Benefits Survey

See Figure CS-2. As in 1998, 2000 survey results show that mammography, breast cancer mastectomy, breast cancer lumpectomy and subsequent breast reconstruction are all covered at 100%. Of note is the lifting of many restrictions on mammography coverage when compared to coverage reported in 1998. With regard to coverage of post-op physical therapy for lymphedema, there has been a decrease in this coverage across all plan types that is statistically significant at $p<.01$. Categories relating to coverage for HPV screening, colposcopy, fecal occult blood screening, and flexible sigmoidoscopy were not included in the 1998 survey.

Comparisons of core coverage between the two surveys was not done because only four items (breast cancer mastectomy, lumpectomy and reconstruction and post-op physical therapy) are common between the two survey years. Mastectomy, lumpectomy and breast reconstruction are covered at 100% in both surveys. The difference in post-op physical therapy coverage (of which there is a statistically significant difference) can be seen in Figure CS-2.

Figure CS-2: Comparison of Reproductive Cancer Services by plan type in 1998 and 2000 surveys.

	HMO (%)		POS (%)		PPO (%)		Indemnity (%)		Overall Coverage (%)	
	n=49	n=51	n=15	n=28	n=20	n=26	n=7	n=9	n=91	n=114
	1998	2000	1998	2000	1998	2000	1998	2000	1998	2000
Mammogram	100	100	100	100	100	100	100	100	*100*	*100*
Mastectomy	100	100	100	100	100	100	100	100	*100*	*100*
Lumpectomy	100	100	100	100	100	100	100	100	*100*	*100*
Breast Recon.	100	100	100	100	100	100	100	100	*100*	*100*
Post-op PT**	98	79	100	86	78	70	86	67	**93**	**77**

**p<.01 ***p<.001 ****p<.0001 'Overall coverage' results in italics were not submitted to tests of difference because there is no difference. 'Overall coverage' results in bold were submitted to the Two-sample Test for Binomial Proportions. 'Overall coverage' results that are shaded are statistically significant at the levels indicated by the asterisks.

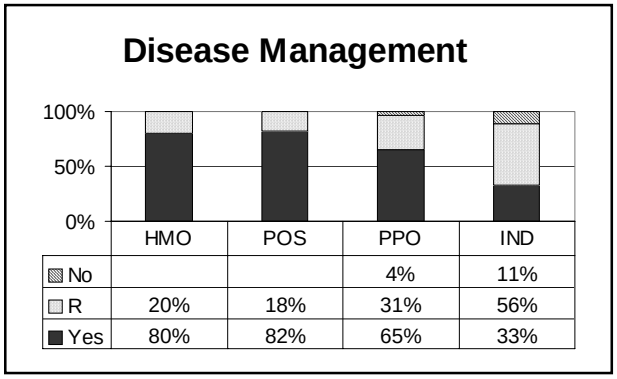
Preventive Care

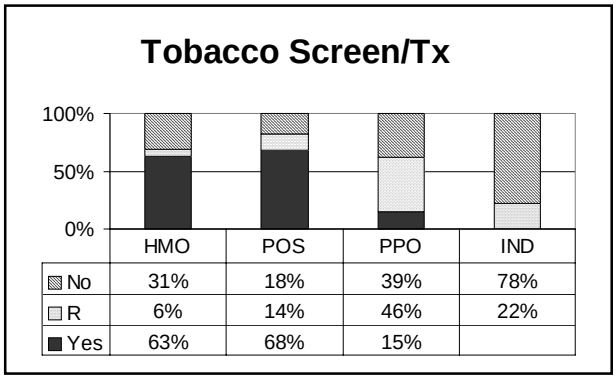
Preventive care services covered in this section of the survey include: chronic disease management and education by provider type; tobacco screening and treatment, including cessation limits; obesity screening and treatment through either surgery, prescription drug treatment or behavior modification; cardiovascular wellness programs (diet, exercise and fitness) pre-CV event or post-CV event; cardiovascular screening (specifically, hypertension, stroke or myocardial infarction risk); and, diabetes screening and prescription management.

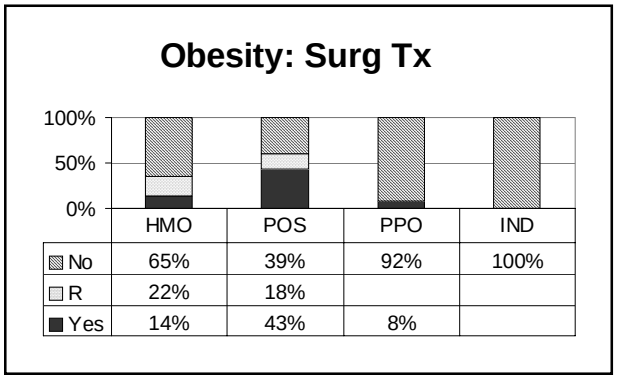
Survey Findings

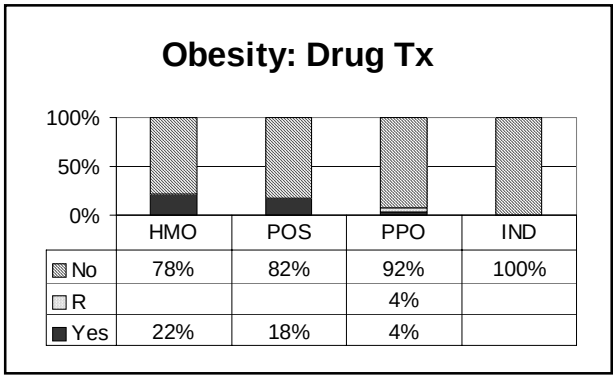
Please see Figure P-1 for a graphical overview of service coverage in each plan type. This figure identifies whether a service is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

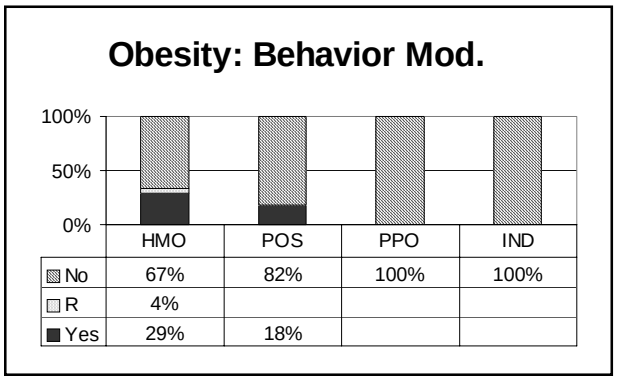
Figure P-1 : Preventive Care Coverage, by Plan Type

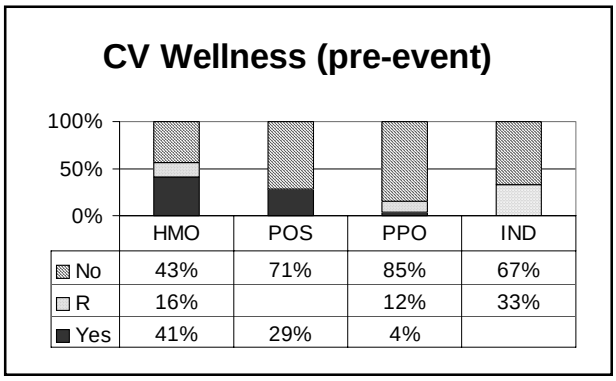


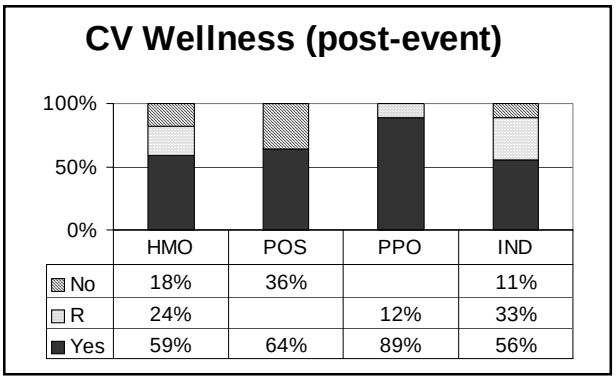


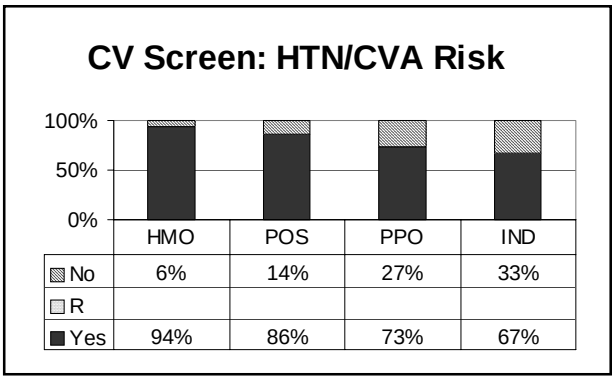


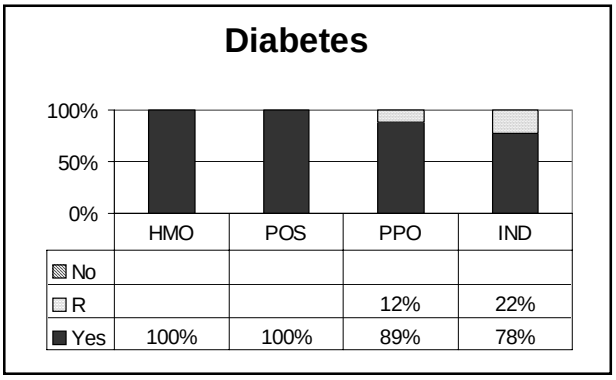












Total Coverage (Routine plus Restricted Responses)

All HMO and POS plans provide coverage for disease management programs and education. Only one PPO plan and one Indemnity plan do not cover such programs, and both plans are no longer for sale. Tobacco screening and treatment are covered in 61% of PPO plans and in 82% of POS plans. Only 22% of Indemnity plans provide coverage, albeit restricted, of tobacco screening and treatment. Overall, treatment of obesity, whether through surgical treatment, drug treatment or behavior modification, has low coverage rates; however, surgical treatment is covered by 61% of POS plans. Cardiovascular wellness programs, including diet, exercise and fitness programs, are covered at higher rates post-cardiac event than pre-cardiac event, except in HMOs, where coverage rates pre-event are relatively high at 57% (routine plus restricted responses). Screening for cardiovascular conditions such as hypertension, stroke and myocardial infarction are covered at high rates in HMO and POS plans (94% and 86% respectively) and at moderate rates in PPO and Indemnity plans (73% and 67% respectively). All plans cover diabetes screening, treatment and management at 100%, although there are some restrictions on coverage in PPO and Indemnity plans.

Restrictions

The majority of restrictions relate to chronic disease management programs. In two managed care plans, education by a dietitian is covered by exception, but there is generally no coverage for pharmacist services. In some plans, coverage is limited to programs administered by contracted providers. One provider limits chronic disease management program coverage in its PPO and Indemnity plans to diabetes and/or smoking cessation programs where the benefit exists. Some cardiovascular wellness programs are restricted to post-event conditions where there is a specific diagnosis. Several providers limit nutritional counseling to a certain number of sessions per condition.

Rider/Age Restrictions/Direct Access/Copayment

Out of all plans surveyed, only 5 plans across all plan types require the purchase of a rider for services included in this section of the survey. Most tobacco cessation program coverage has an annual or lifetime limit and may require purchase of a rider. Diabetes screening, treatment and management in two plans each require purchase of a rider. For example, screening coverage is through a preventive rider, prescription drug coverage is through a prescription drug rider, and medical treatment is a part of the medical benefits. Age restrictions are in effect in 8% of HMO and 32% of POS plans in this survey, all related to the requirement that persons getting surgical treatment of obesity be 20 years of age or older. In the Healthy Options, BHP Plus, and CHIP programs, surgical treatment of obesity requires preauthorization. A little more than half of HMO and POS plans provide direct access to these services, whereas 100% of PPO and Indemnity plans provide direct access. Most HMO and POS plans, and 100% of PPO and Indemnity plans, require co-pays, which vary depending on the product or service and whether or not services are provided in-network.

Comparison to 1998 OIC Reproductive Health Benefits Survey

This section is new to the 2000 survey and thus, no comparison is possible.

Mental Health

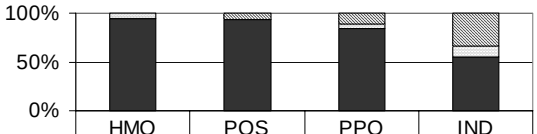
The Mental Health section of the survey asks questions about depression screening and treatment, anxiety screening and treatment, inpatient and outpatient mental health treatment, coverage for prescription treatment (e.g., Zoloft or Prozac), addiction screening and treatment, including by prescription drug, and whether or not there are conditions or diagnoses excluded from the benefit.

Survey Findings

Please see Figure MH-1 for a graphical overview of service coverage in each plan type. This figure identifies whether a service is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

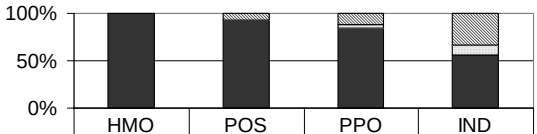
Figure MH-1: Mental Health Care Coverage, by Plan Type

Depression Screen/Tx



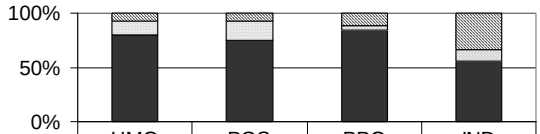
	HMO	POS	PPO	IND
No		7%	12%	33%
R	6%		4%	11%
Yes	94%	93%	85%	56%

Anxiety Screen/Tx



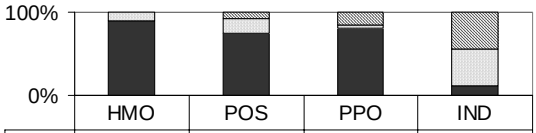
	HMO	POS	PPO	IND
No		7%	12%	33%
R			4%	11%
Yes	100%	93%	85%	56%

Inpatient Tx



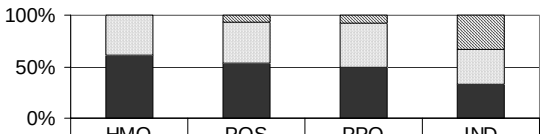
	HMO	POS	PPO	IND
No	8%	7%	12%	33%
R	12%	18%	4%	11%
Yes	80%	75%	85%	56%

Outpatient Tx



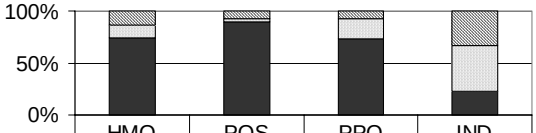
	HMO	POS	PPO	IND
No		7%	15%	44%
R	10%	18%	4%	44%
	90%	75%	81%	11%

Rx Treatment

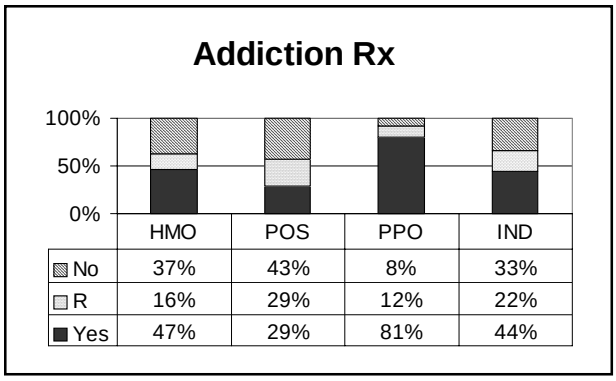


	HMO	POS	PPO	IND
No		7%	8%	33%
R	39%	39%	42%	33%
Yes	61%	54%	50%	33%

Addiction Screen/Tx



	HMO	POS	PPO	IND
No	14%	7%	8%	33%
R	12%	4%	19%	44%
Yes	75%	89%	73%	22%



Total Coverage (Routine plus Restricted Responses)

Screening and treatment rates for depression and anxiety are basically the same in all reported plans. All HMO plans included in this survey cover these services, whereas only 93% of POS plans and 89% of PPO plans provide coverage. Of the nine Indemnity plans reported by carriers, six (67%) provide either routine or restricted coverage. There are differences, by plan type, in coverage for inpatient and outpatient mental health treatment. Inpatient coverage rates range from 67% in Indemnity plans to 92% in HMOs, whereas outpatient coverage rates range from 55% in Indemnity plans to 100% in HMOs. Prescription drug treatment, such as Prozac or Zoloft, is covered by all HMOs, by more than 92% of POS and PPO plans, and by 66% of Indemnity plans. Screening and treatment for addiction are covered at similar rates as coverage for prescription drug treatment, except the rate is lower in HMOs. Coverage for prescription drug therapy for addictions shows variability among plan types, with PPOs showing the highest coverage rates at 93%, and all other plan types showing coverage in about two-thirds of plans included in this survey. Roughly half of HMO, POS and Indemnity plan types exclude certain diagnoses or conditions from these benefits, while only 15% of PPO plans do so.

Restrictions

Most of the services in this section of the survey have one or more restrictions. Three plans require that prescription drugs be in the plan's formulary. Many also require prior authorization before covering certain prescription drugs. Most plans, regardless of type, exclude from coverage those diagnoses that do not respond to short-term therapy. In addition, most plans place time and dollar limits on coverage for inpatient and outpatient therapy, as well as chemical dependency treatment.

Rider/Direct Access/Copayment

For most plans, mental health benefits are available as part of the basic benefit package. In two of the HMOs, inpatient mental health is only covered by a rider. A few plans cover addiction screening and treatment only if the group purchases a rider. The majority of providers responding to this survey noted that prescription drug benefits are available only through a prescription drug rider. The only age restriction among all plans reported for this survey is with Healthy Options, which limits outpatient depression and anxiety screening to once a year for those 21 years of age

or older. Those under 21 years of age have unlimited benefits for depression screening and treatment, and prescription treatment. Most plans (67% to 79%) allow direct access for these services and most (78% to 96%) require a copay.

Comparison to 1998 OIC Reproductive Health Benefits Survey

No comparison is possible, as this section is new to the 2000 survey.

Midlife Health

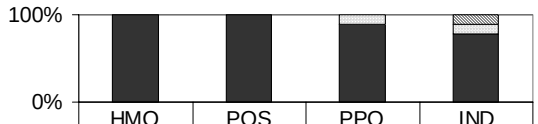
In this section related to women's midlife health, carriers were asked to indicate coverage for incontinence screening and treatment, menopause hormone replacement therapy, menopause alternative therapies (e.g., herbal treatment), arthritis or immune disorders screening and treatment, osteoporosis screening and treatment (including prescription drug therapy), and bone density screening.

Survey Findings

Please see Figure MLH-1 for a graphical overview of service coverage in each plan type. This figure identifies whether a service is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

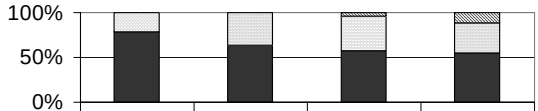
Figure MLH-1: Midlife Health Care Coverage, by Plan Type

Incontinence Screen/Tx



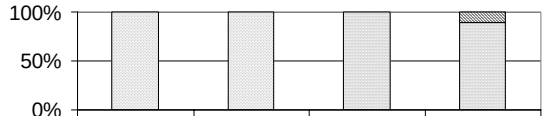
	HMO	POS	PPO	IND
No				11%
R			12%	11%
Yes	100%	100%	89%	78%

Hormone Replacement Tx



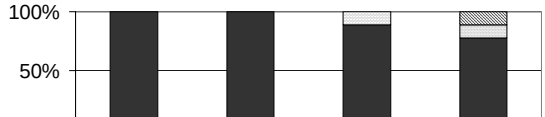
	HMO	POS	PPO	IND
No			4%	11%
R	22%	36%	39%	33%
Yes	78%	64%	58%	56%

Alternative Therapy



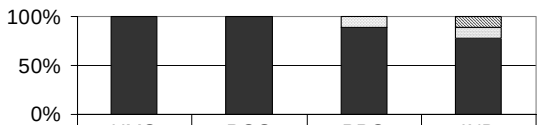
	HMO	POS	PPO	IND
No				11%
R	100%	100%	100%	89%
Yes				

Arthritis/Immune Dis. Screen



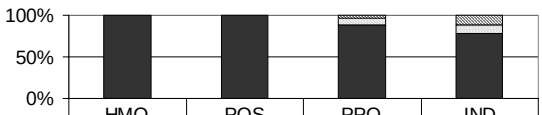
	HMO	POS	PPO	IND
No				11%
R			12%	11%
Yes	100%	100%	89%	78%

Osteoporosis Scr/Tx/Rx



	HMO	POS	PPO	IND
No				11%
R			12%	11%
Yes	100%	100%	89%	78%

Bone Density



	HMO	POS	PPO	IND
No			4%	11%
R			8%	11%
Yes	100%	100%	89%	78%

Total Coverage (Routine plus Restricted Responses)

In essence, all surveyed services relating to women's midlife health are covered, either routinely or with restrictions. These services include incontinence screening and treatment, hormone replacement therapy, alternative therapy, arthritis/immune disorder screening, osteoporosis screening, treatment (including prescription drug treatment) and bone density screening. The one Indemnity plan (out of the nine reported for this survey) that does not cover *any* of these services is one of five plans in the survey that is no longer being sold. The one plan that does not cover bone density screening is an Indemnity-type PPO that also is not currently being sold. The one PPO plan that does not cover hormone replacement therapy (HRT) is an Indemnity-type PPO with very limited coverage across all categories in the survey. To reiterate, essentially all plans surveyed provide coverage for these six services.

Restrictions

Restrictions listed under incontinence, arthritis/immune disorder and osteoporosis generally relate to the screening portion of the category – screening may not be part of the benefit, but diagnosis and treatment are covered. In some plans, coverage for screening tests requires a preventive care rider, but if the test is diagnostic, then it is covered as any other service. Hormone replacement therapy restrictions require a prescription drug benefit for therapy to be covered, including hormone pellet implants. One carrier notes that naturopathic doctor visits are covered, but herbal and over-the-counter therapy is not covered. Essentially, all alternative therapies are restricted. Some require a PCP referral and some need prior authorization. Herbal therapies and supplements are not covered by any plan.

Rider/Direct Access/Copayment

As noted above, some plans require a preventive care rider for coverage of screening tests and a prescription drug rider for coverage of hormone replacement therapy. There are no age restrictions and most plans require a co-pay. Direct access is 100% in PPO and Indemnity plans; twelve (24%) HMO plans and three (11%) POS plans require referral from a gatekeeper.

Comparison to 1998 OIC Reproductive Health Benefits Survey

This section is new to the 2000 survey and, therefore, no comparison is possible.

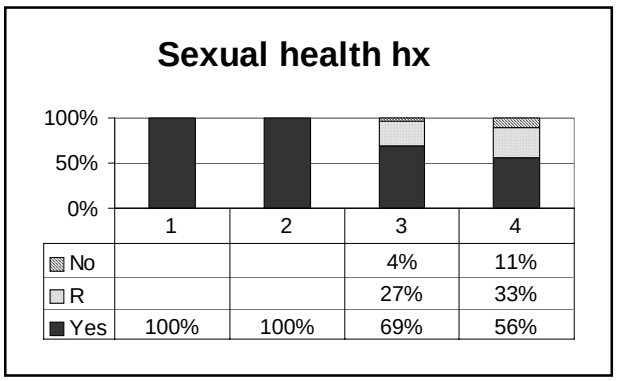
Sexually Transmitted Diseases

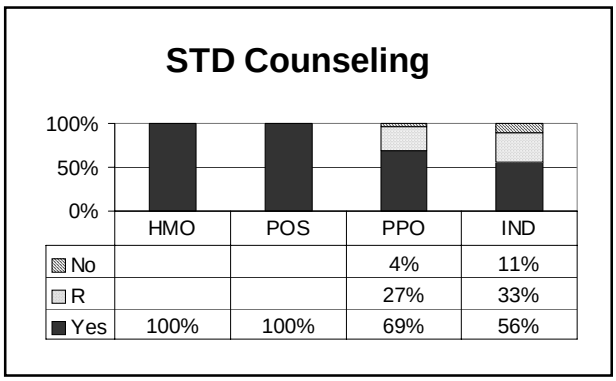
Coverage of sexual health history and STD counseling, screening, diagnosis and treatment is the subject of this section of the survey.

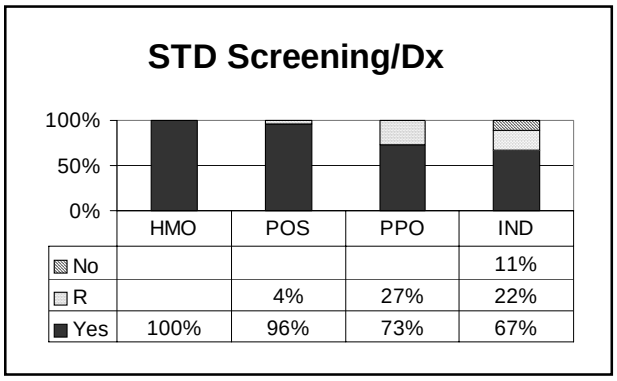
Survey Findings

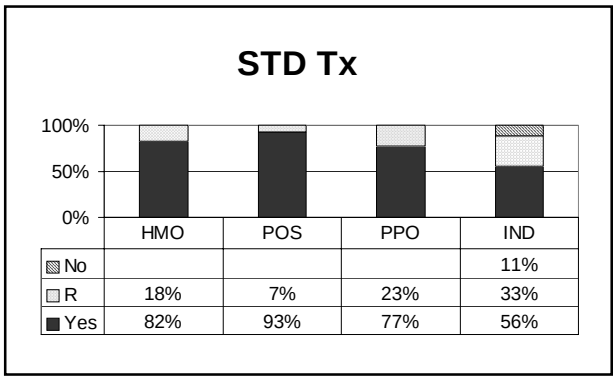
Please see Figure S-1 for a graphical overview of service coverage in each plan type. This figure identifies whether a service is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

Figure S-1: Midlife Health Care Coverage, by Plan Type









Total Coverage (Routine plus Restricted Responses)

Sexual health history-taking and sexually-transmitted disease (STD) counseling, screening, diagnosis and treatment are covered by all plans currently being sold. The only two 'N' responses are from the PPO and the Indemnity plans that are no longer currently being sold.

Restrictions

There are very few restrictions in this category. Comments offered by plans include the coverage requirement that history-taking and counseling be part of a routine office medical visit.

Rider/Direct Access/Copayment

Most plans do not require a rider for coverage of these services. Of the seven plans that do, two are no longer being sold, and the remaining five plans (4 HMOs, 1 PPO) require a preventive care rider to cover screening and a prescription drug benefit to cover prescription drug treatment. There are no age restrictions and almost all subscribers have direct access. Of the six plans that do not offer direct access, five are HMOs that require a PCP referral for treatment by a specialist. The only plans that do not require a co-pay are those offered through the Medical Assistance Administration (Medicaid, Health Options, BHP Plus and CHIP).

Comparison to 1998 OIC Reproductive Health Benefits Survey

See Figure S-2. Compared to the 1998 survey, coverage rates remain near 100%, either through routine or restricted coverage. No overall tests of difference were run because of the virtual lack of difference in coverage rates. Also, there is no statistically significant difference in core coverage rates between 1998 and 2000.

Figure S-2: Comparison of Sexually Transmitted Disease Services by plan type in 1998 and 2000 surveys.

	HMO (%)		POS (%)		PPO (%)		Indemnity (%)		Overall Coverage (%)	
	n=49	n=51	n=15	n=28	n=20	n=26	n=7	n=9	n=91	n=114
	1998	2000	1998	2000	1998	2000	1998	2000	1998	2000
Sex Hlth Hx	100	100	100	100	100	96	100	89	*100*	*98*
Counseling	100	100	92	100	89	96	100	89	*97*	*98*
Screen/Dx	100	100	100	100	94	100	100	89	*99*	*98*
Treatment	100	100	100	100	100	100	100	89	*100*	*99*

'Overall coverage' results in italics were not submitted to tests of difference.

Figure S-3: Comparison of coverage of core services between 1998 and 2000 (screening, diagnosis and treatment); percent and number of females 15-44 years of age and females 45 and over with coverage for all core services.

	1998	2000		
	(%)	(%)	Females 15-44	Females 45 and over
All plan types	99	99	99% (448,980)	99% (254,921)
HMO	100	100	99% (194,243)	100% (95,985)
POS	100	100	100% (75,843)	100% (39,455)
PPO	94	100	100% (165,831)	100% (105,134)
Indemnity	100	89	78% (13,063)	88% (14,347)

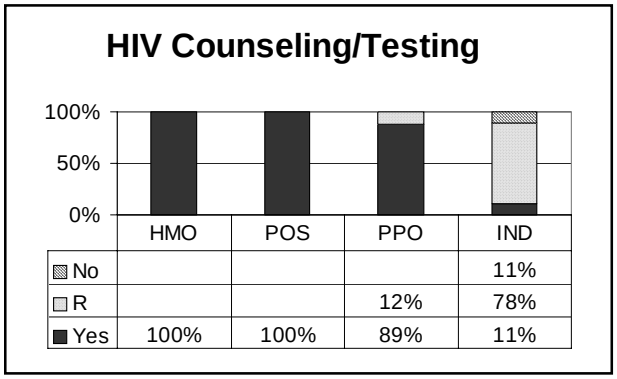
HIV

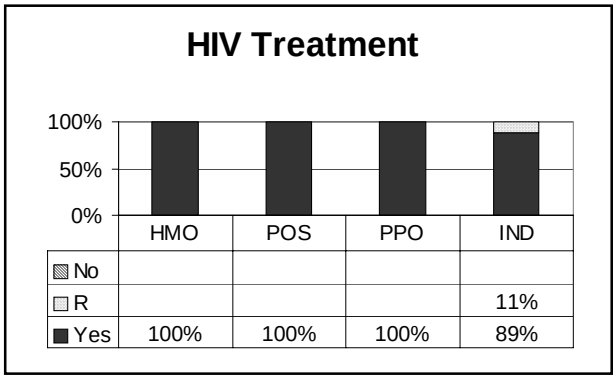
In this section, coverage rates for HIV counseling, testing, and treatment are presented, along with coverage of prescription drugs (including protease inhibitors).

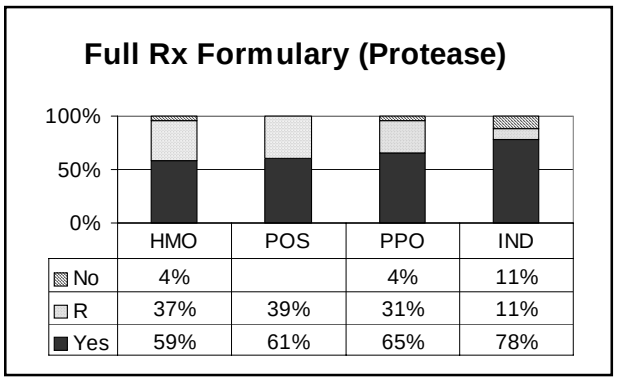
Survey Findings

Please see Figure H-1 for a visual overview of reported service coverage in each plan type, by whether it is covered routinely ('Y'), on a restricted basis ('R'), or not at all ('N').

Figure H-1: HIV Coverage, by Plan Type







Total Coverage (Routine plus Restricted Responses)

All carriers report either routine or restricted coverage of HIV counseling and testing. The one Indemnity plan that does not provide coverage is also the plan that is not currently being sold. All plans cover HIV treatment. Most plans offer full formulary treatment, including protease inhibitors, except for plans offered through the Washington State Health Care Authority or the Medical Assistance Administration, which cover these drugs through the Department of Social and Health Services (DSHS). Two other plans that report no coverage for full formulary drug treatment of HIV are the Indemnity plan that is no longer being sold, and an Indemnity-type PPO.

Restrictions

In general, restrictions relate to the requirement that drug treatment be covered by a prescription drug rider and that screening be covered through a preventive care rider. Prescription drug restrictions in some plans relate to a requirement that prescription drugs be FDA-approved.

Rider/Direct Access/Copayment

As above, riders are required by some plans for coverage of prescription drugs or screening tests. Only a handful of plans have a waiting period (3 to 9 months) for pre-existing conditions. There are no age restrictions. Only one-third (n=17) of HMOs answered 'N' to the direct access question. Of these, five noted that women *do* have direct access for these services and another five noted that treatment by a specialist requires a PCP referral.

Comparison to 1998 OIC Reproductive Health Benefits Survey

See Figures H-2 and H-3. Coverage rates for HIV counseling, testing and treatment remain at essentially 100%, again excluding the 'N' response from the Indemnity plan that is no longer being sold. Since the 1998 survey, coverage of full prescription formulary (including protease inhibitors) remains high, with an increase in coverage by POS plans reporting for the 2000 survey. Overall, coverage rates for full prescription formulary (including protease inhibitors) remains unchanged (95%) from 1998. There is no statistically significant difference in core coverage between the 1998 and 2000 surveys.

Figure H-2: Comparison of HIV Services by plan type in 1998 and 2000 surveys.

	HMO (%)		POS (%)		PPO (%)		Indemnity (%)		Overall Coverage (%)	
	n=49	n=51	n=15	n=28	n=20	n=26	n=7	n=9	n=91	n=114
	1998	2000	1998	2000	1998	2000	1998	2000	1998	2000
Counsel/Test	100	100	100	100	100	100	100	89	*100*	*99*
Treatment	100	100	100	100	100	100	100	100	*100*	*100*
Full Rx Form.	95	96	92	100	94	96	100	89	*96*	*96*

'Overall coverage' results in italics were not submitted to tests of difference.

Figure H-3: Comparison of coverage of core services between 1998 and 2000 (counseling, testing, treatment and full formulary); percent and number of females 15-44 years of age and females 45 and over with coverage for all five core services.

	1998	2000		
	(%)	(%)	Females 15-44	Females 45 and over
All plan types	100	99	99% (452,578)	100% (256,798)
HMO	100	100	99% (194,243)	100% (95,985)
POS	100	100	100% (75,843)	100% (39,455)
PPO	100	100	100% (165,831)	100% (105,134)
Indemnity	100	89	78% (13,063)	88% (14,347)

APPENDIX: SURVEY TOOL

GYNECOLOGICAL CARE

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

CARRIER NAME
PLAN NAME
PLAN TYPE
PLAN CLASS

ENROLLEES/
SUBSCRIBERS
TOTAL
15-44 FEMALE
OVER 45 FEMALE

PAP SMEAR CPT 88150
Yes No R

CHLAMYDIA CPT 87110
Yes No R

ANNUAL EXAM

CPT 99395
Yes No R

CLINICAL BREAST EXAM
Yes No R

SEXUAL DYSFUNCTION SCREENING/Tx/Rx
Yes No R

SEXUAL HEALTH COUNSELING
CPT 99401-4
Yes No R

COVERED AS A RIDER
Yes No R

% ENROLLEES HAVE BENEFIT

AGE RESTRICTION
Yes No R

DIRECT ACCESS
Yes No

COPAY/COINSURANCE/ DEDUCTIBLES
Yes No

RESTRICTIONS/NOTES (DESCRIBE)

MATERNITY SERVICES

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

CARRIER NAME
PLAN NAME
PLAN TYPE
PLAN CLASS

ENROLLEES/
SUBSCRIBERS
TOTAL
15-44 FEMALE
OVER 45 FEMALE

PRECONCEPTION
CPT 99420
Yes No R

PRENATAL TESTING
Yes No R

PRENATAL/OB CARE
CPT 59400
Yes No R

PRENATAL VIT/SUPPL
Yes No R

DELIVERY, HOSPITAL
Yes No R

DELIVERY, HOME
Yes No R

DELIVERY, BIRTH UNIT
Yes No R

LICENSED MIDWIVES BY PROVIDER TYPE
Yes No R

POSTPARTUM CARE
Yes No R

NEWBORN CARE
Yes No R

21-DAY POSTPARTUM CARE OF CHILD OF DEPENDENT
Yes No R

PRENATAL CARE OF TEEN DEPENDENTS
Yes No R

COVERED AS A RIDER
Yes No R

% ENROLLEES HAVE BENEFIT

RESTRICTIONS ON # BIRTHS OR $ LIMIT
Yes No

BENEFIT WAIT PERIOD
Yes No R

DIRECT ACCESS
Yes No

COPAY/COINSURANCE /DEDUCTIBLE
Yes No

RESTRICTIONS/NOTES (DESCRIBE)

CONTRACEPTION/FAMILY PLANNING
List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

CARRIER NAME
PLAN NAME
PLAN TYPE
PLAN CLASS

ENROLLEES/ SUBSCRIBERS
TOTAL
15-44 FEMALE
OVER 45 FEMALE

CONTRACEPTIVE COUNSELING
CPT 99401
Yes No R

OTC CONTRACEPTION
Yes No R

INTRAUTERINE DEVICE
Yes No R

IUD INSERTION
CPT 58300
Yes No R

IUD REMOVAL
Yes No R

DIAPHRAGM DEVICE
Yes No R

DIAPHRAGM/CAP FIT
CPT 57170
Yes No R

NORPLANT DEVICE
Yes No R

NORPLANT INSERTION
CPT 11975
Yes No R

NORPLANT REMOVAL
CPT 11976
Yes No R

DMPA INJECTION
CPT 01050
Yes No R

ORAL CONTRACEPTIVE PILLS
Yes >1mo No R

EMERGENCY CONTRACEPTION
Yes No R

DOES PLAN HAVE RX DRUG BENEFIT
Yes No R

ARE CONTRACEPTIVES PART OF RX DRUG BENEFIT
Yes No R

ARE CONTRACEPTIVES EXCLUDED FROM RX BENEFIT (DESCRIBE WHICH ARE EXCLUDED IN NOTES)
Yes No R

COVERED AS A RIDER
Yes No R

% ENROLLEES HAVE BENEFIT

DIRECT ACCESS
Yes No

COPAY/COINSURANCE/ DEDUCTIBLE
Yes No

RESTRICTIONS/NOTES (DESCRIBE)

INFERTILITY
List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe

Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

CARRIER NAME
PLAN NAME
PLAN TYPE
PLAN CLASS

ENROLLEES/
SUBSCRIBERS
TOTAL
15-44 FEMALE
OVER 45 FEMALE

INFERTILITY DIAGNOSIS
Yes No R

INFERTILITY TREATMENT
Yes No R

ENDOMETRIAL BIOPSY
CPT 58100
Yes No R

ENDOMETRIOSIS TREATMENT
Yes No R

ASSISTED REPRODUCTIVE TECHNOLOGIES; IF YES, SPECIFY TX
Yes No R

COVERED AS A RIDER
Yes No R

% ENROLLEES HAVE BENEFIT

BENEFIT WAIT PERIOD
Yes No

AGE RESTRICTION
Yes No

DIRECT ACCESS
Yes No

COPAY/COINSURANCE/ DEDUCTIBLE
Yes No

RESTRICTIONS/NOTES (DESCRIBE)
Cost/duration Limits

CANCER SCREENING

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

CARRIER NAME
PLAN NAME
PLAN TYPE
PLAN CLASS

ENROLLEES/
SUBSCRIBERS
TOTAL
15-44 FEMALE
OVER 45 FEMALE

PAP SCREEN
Yes No R

HPV SCREEN
Yes No R

COLPOSCOPY SCREEN
Yes No R

FECAL OCCULT BLOOD SCREEN
Yes No R

FLEX SIGMOIDOSCOPY SCREEN
Yes No R

MAMMOGRAPHY
CPT 76092
Yes No R

BREAST CANCER MASTECTOMY
Yes No R

BREAST CANCER LUMPECTOMY
Yes No R

BREAST RECONSTRUCTION
Yes No R

LYMPHEDEMA – PROVIDER TYPE/LIMITS SCREEN/TX
Yes No R

WHEN POSTOP PHYSICAL THERAPY REHAB LIMITS APPLY
Yes No R

COVERED AS A RIDER
Yes No R

% ENROLLEES HAVE BENEFIT

DIRECT ACCESS
Yes No

COPAY/COINSURANCE/ DEDUCTIBLE
Yes No

RESTRICTIONS/NOTES (DESCRIBE)

PREVENTIVE CARE

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

CARRIER NAME
PLAN NAME
PLAN TYPE
PLAN CLASS

ENROLLEES/ SUBSCRIBERS
TOTAL
15-44 FEMALE
OVER 45 FEMALE

CHRONIC DISEASE MGMT & EDUCATION BY PROVIDER TYPE; RD, PHARMACIST
Yes No R

TOBACCO SCREEN, TX/ CESSATION LIMITS
Yes No R

OBESITY SCREEN, TX SURGERY
Yes No R

OBESITY SCREEN, TX RX
Yes No R

OBESITY TX BY BEHAVIOR MODIFICATION
Yes No R

CARDIOVASCULAR PROGRAMS – DIET/EXERCISE – FITNESS – WELLNESS PRE CVD EVENT
Yes No R

CARDIOVASCULAR PROGRAMS – DIET/EXERCISE – FITNESS – WELLNESS POST CVD EVENT
Yes No R

CARDIOVASCULAR SCREEN (HYPERTENSION/ STROKE/MI RISK)
Yes No R

DIABETES SCREEN, RX MGMT
Yes No R

COVERED AS A RIDER
Yes No R

% ENROLLEES HAVE BENEFIT

AGE RESTRICTION
Yes No R

DIRECT ACCESS
Yes No

COPAY/COINSURANCE/ DEDUCTIBLE
Yes No

RESTRICTIONS/NOTES (DESCRIBE)

MENTAL HEALTH

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

CARRIER NAME
PLAN NAME
PLAN TYPE
PLAN CLASS

ENROLLEES/ SUBSCRIBERS
TOTAL
15-44 FEMALE
OVER 45 FEMALE

DEPRESSION SCREEN, TX
Yes No R

ANXIETY SCREEN, TX
Yes No R

IN-PATIENT
Yes No R

OUT-PATIENT
Yes No R
RX (e.g. ZOLOFT, PROZAC, ETC)
Yes No R

ADDICTION SCREEN, TX
Yes No R

ADDICTION RX
Yes No R

CONDITIONS/DIAGNOSES EXCLUDED FROM BENEFIT
Yes No R

COVERED AS RIDER
Yes No R

% ENROLLEES HAVE BENEFIT

AGE RESTRICTION
Yes No R

DIRECT ACCESS
Yes No

COPAY/COINSURANCE/ DEDUCTIBLE
Yes No

RESTRICTIONS/NOTES (DESCRIBE)

MIDLIFE HEALTH

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

CARRIER NAME
PLAN NAME
PLAN TYPE
PLAN CLASS

ENROLLEES/ SUBSCRIBERS
TOTAL
15-44 FEMALE
OVER 45 FEMALE

INCONTINENCE SCREEN, TX
Yes No R

MENOPAUSE HORMONE REPLACEMENT THERAPY
Yes No R

MENOPAUSE ALTERNATIVE THERAPIES (e.g. HERBAL TX)
Yes No R

ARTHRITIS/IMMUNE DISORDERS SCREEN, TX
Yes No R

OSTEOPOROSIS SCREEN, TX, RX
Yes No R

BONE DENSITY
Yes No R

COVERED AS A RIDER
Yes No R

% ENROLLEES HAVE BENEFIT

AGE RESTRICTION
Yes No R

DIRECT ACCESS
Yes No

COPAY/COINSURANCE/ DEDUCTIBLE
Yes No

RESTRICTIONS/NOTES (DESCRIBE)

SEXUALLY TRANSMITTED DISEASES

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

CARRIER NAME
PLAN NAME
PLAN TYPE
PLAN CLASS

ENROLLEES/ SUBSCRIBERS
TOTAL
15-44 FEMALE
OVER 45 FEMALE

SEXUAL HEALTH HX-TAKING
Yes No R

STD COUNSELING
Yes No R

STD SCREENING, DX
Yes No R

STD TX
Yes No R

COVERED AS A RIDER
Yes No R

% ENROLLEES HAVE BENEFIT

AGE RESTRICTION
Yes No

DIRECT ACCESS
Yes No

COPAY/COINSURANCE/ DEDUCTIBLE
Yes No

RESTRICTIONS/NOTES (DESCRIBE)
Cost/duration Limits

HIV

List your 5 best selling group plans, and 2 best selling individual plans, and describe whether the benefit includes the core services listed below by indicating 'Yes/No'. If these services are covered only as a rider, please mark 'Yes' in the "Rider" column. If the benefit is offered but has restrictions, mark 'R*' and describe Restriction(s) in last column. Describe any additional services that are part of the package in the "Notes" column. Under "Plan Classification", indicate whether your plan is a 'PPO', 'POS', 'MGD CARE' (uses PCP & provider network) or 'INDM' (indemnity) model.

CARRIER NAME
PLAN NAME
PLAN TYPE
PLAN CLASS

ENROLLEES/ SUBSCRIBERS
TOTAL
15-44 FEMALE
OVER 45 FEMALE

HIV COUNSELING & TESTING
Yes No R

HIV TX
Yes No R

FULL RX FORMULARY (PROTEASE)
Yes No R

COVERED AS A RIDER
Yes No R

% ENROLLEES HAVE BENEFIT

BENEFIT WAIT PERIOD
Yes No

AGE RESTRICTION
Yes No

DIRECT ACCESS
Yes No

COPAY/COINSURANCE/ DEDUCTIBLE
Yes No

RESTRICTIONS/NOTES (DESCRIBE)
Cost/duration Limits